The Hetrick Center
Medical History Questionnaire Update

Patient Name: _____ **DOB:** _____

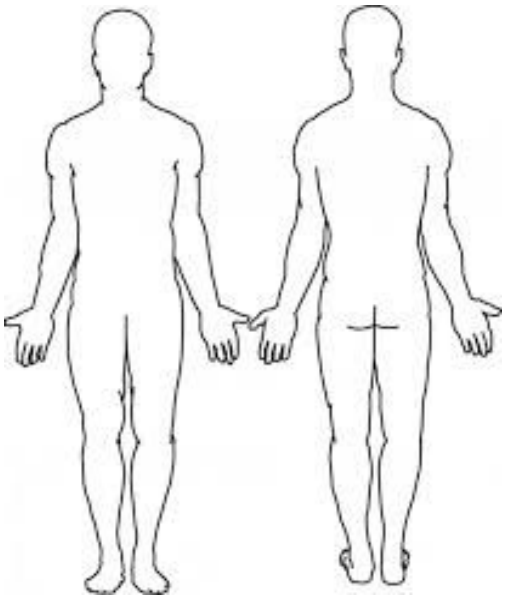
Preferred Phone #: _____ Email Address: _____
Height: _____ Weight: _____ Blood Pressure: _____

Emergency Contact Person
Name: _____ Phone: _____

History of Current Condition
What brings you in today? _____
_____

Pain

1) What type of pain is it? (*circle all that apply*)
   Sharp/Stabbing Aching Dull Throbbing
   Numbness Tingling Cramping Burning
2) Rate pain on a scale of 0 to 10 *(circle answers)*
   (0 = no pain, 10 = worst imaginable pain)
   Currently 1 2 3 4 5 6 7 8 9 10
   Average 1 2 3 4 5 6 7 8 9 10
   At Best 1 2 3 4 5 6 7 8 9 10
   At Worst 1 2 3 4 5 6 7 8 9 10
3) How long have you had this pain?
   _____
   Date of Onset _____
4) What makes the pain worse?
   _____
   _____
5) What makes the pain better?
   _____
   _____
6) Does the pain travel? If so, where?
   _____
7) Is the pain worse at any particular time of day?
   _____
8) The pain is getting: *(circle)*
   Better Worse Staying the Same



FRONT BACK

To help us better understand the nature and origin of your complaints, we ask that you carefully use the symbols below to complete this drawing. Detail where your symptoms are located and what type of symptoms you have in each affected area on the figures.

// Dull/Ache/Throb ⁘ Tingling O Numbness

B Burning C Cramping X Sharp/Stabbing

Additional Comments:
_____
_____
_____

Please list all current and past medical conditions and note if they are under current medical treatment:

1._____ 5. _____

2._____ 6._____

3._____ 7._____

4. _____ 8._____

Have you ever received x-rays? Yes ____ No ____
If yes, for what? _____ Date: _____

Have you ever received an MRI? Yes ____ No ____
If yes, for what? _____ Date: _____

Have you ever had other clinical tests? *(check all that apply)*

▢ Angiogram	▢ Blood Tests	▢ Doppler Ultrasound	▢ Mammogram	▢ Urine / Stool Tests
▢ Bone Scan	▢ Biopsy	▢ Echocardiogram	▢ Myelogram	▢ Stress Tests
▢ Arthroscopy	▢ CT Scan	▢ EEG / EKG	▢ EMG/NCV	

▢ Other: _____

Is your current condition related to a work injury or an automobile accident? Yes ____ No ____
If yes, please make your THC provider aware immediately. Date of accident/injury: _____

Have you ever sustained a work injury for which you received treatment? Yes ____ No ____
Date of injury: _____

Please list surgeries, medical procedures, and/or hospitalizations:

1)_____ Date:_____ 5)_____Date:_____

2)_____ Date:_____ 6)_____Date:_____

3)_____ Date:_____ 7)_____Date:_____

4)_____ Date:_____ 8)_____Date:_____

When was the last time you followed-up with your family physician? Date:_____

General Health Questions

Do you use tobacco products? Yes ____ No ____ If yes, indicate how much you use (ie packs / day) and for how long you have used the products. _____

Do you drink alcohol? Yes ____ No ____ If yes, indicate how much and what type of alcohol you consume per week.
_____

Is your history significant for recreational drug use? Yes ____ No ____
If yes, please describe. _____

My diet is: ▢ Balanced ▢ Not Balanced
Recent Weight Change: ▢ Gained ▢ Lost How much? _____

My rest is: ▢ Sufficient ▢ Insufficient Hours of sleep per night? _____

My recreation is: ▢ Sufficient ▢ Insufficient

I exercise: ▢ 0 x / week ▢ 1-2 x / week ▢ 3-4 x / week ▢ 5 or more x / week
My overall stress is: ▢ Severe ▢ Moderate ▢ Minimal ▢ None

Thank you for completing this form.
The information you have provided will assist us in attending to your healthcare needs.

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a rehabilitation exercise program or care designed for me if determined to be clinically medically necessary by my doctor or therapist. I will notify them of any changes in my health status during the duration of my program. It is also my duty to inform the doctor, therapist, or assistant of any possible complication prior to the initiation of my daily rehabilitation or treatment.

Your Signature _____ Date: _____

THC Provider Signature _____ Date: _____

- ▢ **Ed Bartakovits, DC**
- ▢ **Mary Colman, DC**
- ▢ **Scott Colman, DC**
- ▢ **Timothy Duke, DC, CICE**
- ▢ **Jennifer Green, DC**
- ▢ **Edward Hevner, DC**
- ▢ **Charlene B. Hobbie, DC**
- ▢ **Daniel Pavelko, DC**
- ▢ **John Renda, DC**
- ▢ **Allyson M. Bell PT, DPT**
- ▢ **Christy Carroll PT, MSPT**
- ▢ **Corinna Parsons PT, DPT**

Current Medications / Supplements

Patient Name: _____Date: _____

▫ Check here if you have attached your own list of medications.

Medication / Supplement Name	Dosage	Frequency	Date you started taking it

Please list any known allergies (ie. medications, stings, foods, Latex, etc.) and what your reaction is:

_____

_____

_____

Please keep us updated on any changes in medication(s) or supplement(s) that you are taking by reprinting and resubmitting this form. Thank you.