The Hetrick Center
Medical History Questionnaire

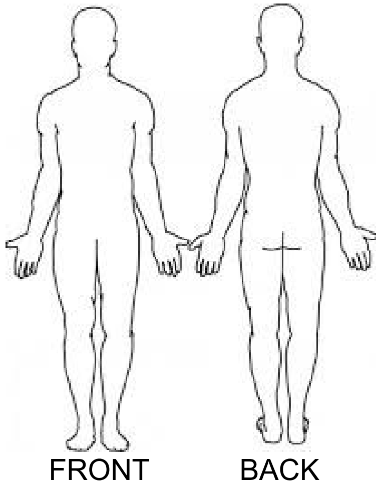
Patient Name: ________________________ **DOB:** ____________
Preferred Phone #: ____________________ Email Address: ____________________
Height: __________ Weight: __________ Blood Pressure: __________

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



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: ______________________________
____
____
____

Family History
Do you have any children? If yes, list name(s), sex and age(s).: ______________________________
____
Do your children have any medical issues (past or present)? ______________________________
____
If you have sibling(s), do they have any medical issues? Please list: ______________________________
____
Do/Did your parents have any medical issues? Please list: ______________________________
____

Do/Did your maternal or paternal grandparents have any medical issues? Please list: ____________________________
____

Your Personal Medical History

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:__________ 3)____________________________Date:__________
2)__________________________Date:__________ 4)____________________________Date:__________

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

Home Environment:

Describe your home/work/recreational activities and any difficulties that you have with these activities.:____
With whom do you live?: ____
Do you use an assistive device for locomotion? Yes ____ No ____
If so, type of device: ▢ Wheelchair ▢ Wheeled walker ▢ Standard walker ▢ Cane
Does your home have: ▢ Stairs, no railing(s) ▢ Stairs, with railing(s) ▢ Ramps ▢ Elevator ▢ Uneven terrain
Other obstacles: _________________________________ Other devices: _______________________________
My family stress is: ▢ Severe ▢ Moderate ▢ Minimal ▢ None

Occupation

Occupation (ie. job title, work duties):____
____
My job stress is: ▢ Severe ▢ Moderate ▢ Minimal ▢ None

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
I have experienced: ▢ Nervousness ▢ Irritability ▢ Fatigue ▢ Depression
▢ Run down feeling ▢ Craving for sweets ▢ Craving for salt

Please check the box if you have any of the following issues:

▢ AIDS	▢ Diabetes	▢ High blood pressure	▢ Polio
▢ Anemia	▢ Epilepsy	▢ HIV	▢ Rheumatic fever
▢ Arthritis	▢ Hardening of the arteries	▢ Low blood sugar	▢ Stroke
▢ Cancer	▢ Heart attack	▢ Multiple Sclerosis	▢ Tuberculosis
▢ Diabetes	▢ Hepatitis C	▢ Parkinson Disease	▢ Venereal disease

Do you have a history of cancer? Yes ____ No ____
If yes, please describe: ____________________

Review of Systems

Head - ▢ Check here if you have no issues with this system

▢ Facial numbness (*circle* : right or left)
▢ Loss of balance
▢ Unusually severe headaches
▢ Head feels heavy
▢ Previous head trauma
▢ Vertigo
▢ Lightheadedness
▢ Unusually frequent headaches

Neck - ▢ Check here if you have no issues with this system

▢ Abnormal sounds in neck
▢ Neck feels out of place
▢ Previous neck injury
▢ Dizziness with neck movement
▢ Neck pain with movement
▢ Stiff neck
▢ Muscle spasms in neck
▢ Pinched nerve in neck (*circle* : right or left)
▢ Swelling in neck

Shoulders - ▢ Check here if you have no issues with this system

▢ Can't raise arm(s) above shoulder level
▢ Pain across shoulders
▢ Tension in shoulders
▢ Can't raise arm(s) overhead
▢ Pain in shoulder (*circle* : right or left)
▢ Muscle spasms in shoulder
▢ Previous shoulder injury

Arms / Hands - ▢ Check here if you have no issues with this system

▢ Cold hands
▢ Pain in fingers (*circle* : right or left)
▢ Fingers fall asleep (*circle* : right or left)
▢ Previous injury to hand(s)
▢ Loss of grip strength (*circle* : right or left)
▢ Sensation of pins & needles in arm(s)
▢ Pain in upper arm(s) (*circle* : right or left)
▢ Sensation of pins & needles in hand(s)
▢ Pain in forearm(s) (*circle* : right or left)
▢ Sore finger joints
▢ Pain in hand(s) (*circle* : right or left)
▢ Swollen finger joints

Mid-back - ▢ Check here if you have no issues with this system

▢ Mid-back pain (*circle* : right or left)
▢ Pain from front to back
▢ Muscle spasms in mid-back
▢ Pain over kidney area (*circle* : right or left)
▢ Pain below shoulder blades with exercise
▢ Previous mid-back injury
▢ Pain between shoulder blades

Lower Back - ▢ Check here if you have no issues with this system

▢ Lower back feels out of place
▢ Muscle spasms in lower back
▢ Lower back pain (*circle* : right or left)
▢ Previous lower back injury

Hips / Legs / Feet - ▢ Check here if you have no issues with this system

▢ Cold feet
▢ Pain in buttock(s) (*circle* : right or left)
▢ Knee pain (*circle* : right or left)
▢ Pain down leg(s) (*circle* : right or left)
▢ Leg cramps (*circle* : right or left)
▢ Previous hip/leg/foot injury
▢ Numbness in leg(s) (*circle* : right or left)
▢ Sensation of pins and needles
▢ Numbness in toes (*circle* : right or left)
▢ Swollen feet

Cardiovascular -* ▢ *Check here if you have no issues with this system

▢ Blue/purple skin ▢ Fainting ▢ High blood pressure ▢ Rapid heartbeat
▢ Chest pain ▢ General swelling ▢ Irregular heartbeat ▢ Swelling in face
▢ Chest pain with exercise ▢ Heart jumps ▢ Poor circulation ▢ Swelling in legs / feet
▢ Difficulty lying flat ▢ Heart murmur ▢ Pounding heartbeat

Hair / Skin / Nails -* ▢ *Check here if you have no issues with this system

▢ Allergies to chlorine ▢ Dry skin ▢ Oily scalp ▢ Psoriasis ▢ Skin cancer
▢ Baldness ▢ Eczema ▢ Oily skin ▢ Rashes ▢ Yellow skin
▢ Bruise easily ▢ Itchy skin ▢ Pale skin ▢ Rough, scaly scalp
▢ Dry scalp ▢ Nail biting ▢ Paper skin nails ▢ Sensitive skin

Eyes -* ▢ *Check here if you have no issues with this system

▢ Blurred vision ▢ Excessive tearing ▢ Light bothers eyes ▢ Pain in eyes
▢ Double vision ▢ Eyes fatigue easily ▢ Night blindness ▢ Periods of blindness
▢ Excessive eye itching ▢ Lack of tearing ▢ Pain behind eyes ▢ Redness in eyes

Ears -* ▢ *Check here if you have no issues with this system

▢ Discharge from ears ▢ Pain in ears (*circle* : right or left) ▢ Vertigo
▢ Hearing loss (*circle* : right or left) ▢ Ringing in ears (*circle* : right or left)

Nose / Nasopharynx/Sinuses -* ▢ *Check here if you have no issues with this system

▢ Frequent colds ▢ Nose bleeds ▢ Sinusitis
▢ Loss of smell ▢ Obstruction of nose ▢Trauma to nose (previous or current)
▢ Nasal allergies ▢ Pressure over or under eyes ▢ Unusual nasal discharge

Mouth / Throat -* ▢ *Check here if you have no issues with this system

▢ Abscessed teeth ▢ Changes in voice ▢ Loss of taste
▢ Bleeding gums ▢ Dentures ▢ Pain in mouth
▢ Cavities ▢ Difficulty swallowing ▢ Pain in throat

Respiratory -* ▢ *Check here if you have no issues with this system

▢ Abscessed teeth ▢ Cavities ▢ Dentures ▢ Pain in mouth
▢ Bleeding gums ▢ Changes in voice ▢ Difficulty swallowing ▢ Pain in throat

Gastrointestinal -* ▢ *Check here if you have no issues with this system

▢ Abdominal bloating ▢ Hemorrhoids ▢ Stomach gas before meals
▢ Abdominal pain ▢ Hepatitis ▢ Stomach gas with meals
▢ Change in bowel habits ▢ Indigestion ▢ Stomach gas after meals
▢ Constant nibbling ▢ Jaundice ▢ Stomach upsets with food
▢ Constipation ▢ Liver disease ▢ Stomach upsets with liquid
▢ Diarrhea ▢ Loss of bowel control ▢ Stomach upsets with medication(s)
▢ Gallbladder disease ▢ Poor appetite ▢ Ulcers
# of bowel movements per day: ____________

Genitourinary - Check here if you have no issues with this system

▢ Back pain with urination ▢ Dribbling ▢ Lack of bladder control
▢ Blood in urine ▢ Difficulty to start / stop urination ▢ Night urination
▢ Cloudy urine ▢ Incontinence ▢ Painful urination
Urination is: *(circle)* frequent infrequent ▢ Stream flow abnormality
Amount is: *(circle)* high low

Female Only -* ▢ *Check here if you have no issues with this system

▢ Excessive menstrual flow ▢ Ovarian cysts
▢ Fibroid tumors ▢ Painful periods
▢ Irregular cycles ▢ Premenstrual symptoms
▢ Low back pain with menses ▢ Spotting
▢ Low back pain with pregnancy ▢ Tubal Pregnancy
▢ Lumps in breasts ▢ Urine leakage
▢ Missed period(s) ▢ Vaginal discharge ▢ Wear an IUD

Date of last menstrual period: ____________
Number of pregnancies:________________
Number of vaginal deliveries: ____________
Number of C-sections: __________________
Number of complicated deliveries: _________

Male Only -* ▢ *Check here if you have no issues with this system

▢ Blood in sperm ▢ Premature ejaculation ▢ Testicular masses
▢ Impotence ▢ Prostate disease ▢ Testicular swelling / pain

Thank you or 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**
- ▢ **Corrina 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.