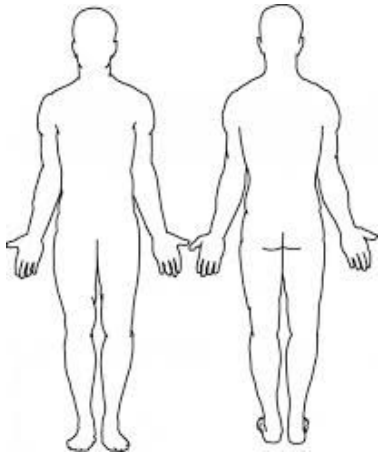
The Hetrick Center
Medical History Questionnaire

Patient Name: _____ **DOB:** _____
Preferred Phone #: _____ Email Address: _____
Height: _____ Weight: _____ Blood Pressure: _____
Primary Care Physician Name : _____ Phone: _____
How did you hear about us? _____

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: _____
_____
_____
_____

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? _____ lbs.

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

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 (Type 2)	▢ 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 (Type 1)	▢ 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* : left or right)	
▢ 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* : left or right)
▢ Fingers fall asleep	(*circle* : left or right)	▢ Previous injury to hand(s)	
▢ Loss of grip strength	(*circle* : left or right)	▢ Sensation of pins & needles in arm(s)	
▢ Pain in upper arm(s)	(*circle* : left or right)	▢ Sensation of pins & needles in hand(s)	
▢ Pain in forearm(s)	(*circle* : left or right)	▢ Sore finger joints	
▢ Pain in hand(s)	(*circle* : left or right)	▢ Swollen finger joints	

Mid-back -

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

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

Lower Back -

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

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

Hips / Legs / Feet -

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

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

Cardiovascular -

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

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

Hair / Skin / Nails -

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

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

Eyes -

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

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

Ears -

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

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

Nose / Nasopharynx/Sinuses -

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

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

Mouth / Throat -

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

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

Respiratory -

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

▢ Abnormal chest x-ray
▢ Asthma
▢ Chronic cough
▢ Coughing up blood
▢ Difficulty breathing when lying down
▢ Difficulty sleeping when lying down
▢ Dry cough
▢ Productive cough
▢ Shortness of breath
▢ Wheezing

Gastrointestinal -

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

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

Genitourinary -

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

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

Female Only -

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

▢ Excessive menstrual flow
▢ Fibroid tumors
▢ Irregular cycles
▢ Low back pain with menses
▢ Low back pain with pregnancy
▢ Lumps in breasts
▢ Missed period(s)
▢ Ovarian cysts
▢ Painful periods
▢ Premenstrual symptoms
▢ Spotting
▢ Tubal Pregnancy
▢ Urine leakage
▢ Vaginal discharge
Date of last menstrual period: _____
Number of pregnancies:_____
Number of vaginal deliveries: _____
Number of C-sections: _____
Number of complicated deliveries: _____
▢ Wear an IUD

Male Only -

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

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

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**
▢ **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.