Jeny Bauer, DPT

HEALTH ENHANCEMENT CENTERS

The Health Enhancement Centers, PA

104 W Redwood St Marshall, MN 56258 (507) 337-2457 f(507) 532-2951 www.HECMN.com

Today's Date: ___/___/____

❒Male ❒Female Pregnant? ❒No ❒ Yes, due date? __/__/__ Social Security # ___ ___ ___/___ ___/___ ___ ___ ___

Last Name_____ Legal First Name_____ DOB: ___/___/___

Preferred Name_____ Address:_____
(Address) (City) (State) (Zip Code)

Home Phone: (_____)_____-_____ Cell phone: (_____)_____-_____ Work phone: (_____)_____-_____

Email address: _____

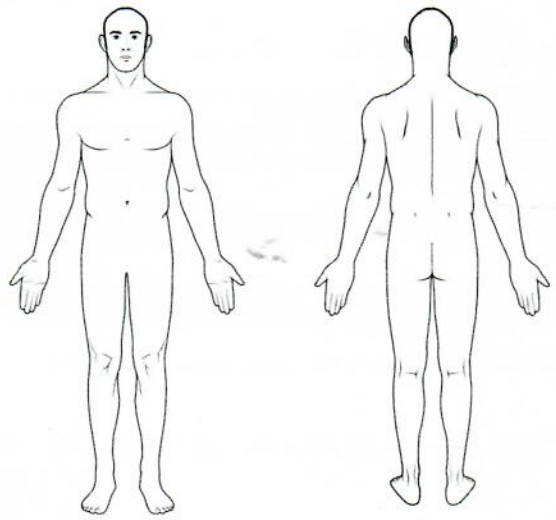
1. Describe your injury/problem and how/when it started. If you had surgery, what was the date of your surgery? _____

   _____

2. Please describe your pain *(i.e. dull/sharp/achy, etc).* _____

   _____

3. Using body diagram, please locate your pain. *(Please mark diagram below with circles or x)*



4. Pain scale: *(please circle)* *No pain* 1 2 3 4 5 6 7 8 9 10 *Severe pain*

5. What relieves your pain? _____

6. What increases your pain? _____

7. Have you had therapy before? ❒Yes ❒No.
   If yes, did it help?_____

8. Have you seen another practitioner for this issue: *(Check all that apply)*

❒Chiropractor	❒Neurologist	❒Gynecologist
❒Massage	❒Family Practitioner	❒Orthotist
❒Podiatrist	❒Orthopedist	❒Other_____

9. Have you had any kind of special testing: *(Check all that apply)*

❒ultrasound ❒MRI ❒nerve conduction test
❒x-ray ❒CT scan ❒other:_____

10. Do you have difficulties with any of the following? *(Check all that apply)*

❒Sitting ❒Driving/Riding in a car ❒Home Maintenance *(fixing/repairing, mowing/shoveling, etc...)*
❒Standing ❒Sleeping
❒Lifting ❒Getting up ❒Dressing/Grooming
❒Walking ❒Household activities *(dishes, vacuuming, dusting, etc...)* ❒Other_____
❒Bending
❒Reaching

11. List previous surgeries/broken bones. _____

12. Please list your occupation/recreational activities and if they are limited. _____

_____

13. Do you have/had any of the following: *(Check all that apply)*

❒cancer ❒blood pressure issues ❒history of falls with injury
❒rheumatoid arthritis ❒pregnant ❒allergy to latex or
❒heart problems ❒fibromyalgia medications *(list)* _____
❒previous stroke ❒diabetes _____

14. Are you currently taking medications, prescription drugs, and pain killers? ❒No ❒Yes
(Please include regularly used over the counter medications)

Prescription Name	Dosage	Frequency	What is it for?

15. What are your goals for participating in physical therapy? *(i.e. decrease pain, be able to reach into cupboards, etc.)*

Waiver: I have been offered a copy of HEC's *HIPAA HITEC consent*, and the following person(s) have permission to any and all of my records (if applicable)._____

*(signature)*_____ *(date)* ___/___/___

Waiver: I consent to physical therapy treatment. I understand the risks are minimal. I authorize all billing and communication with my insurance.

*(signature)*_____ *(date)* ___/___/___

Office Use Only	*HT:*	*WT:*	*lbs*	*BP:*	/	*O2:*	*Pulse:*