The Health Enhancement Centers, P.A.

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Jeny Bauer, DPT

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: ____

Marital Status: ____________________________ Employment Status: ___________________________________

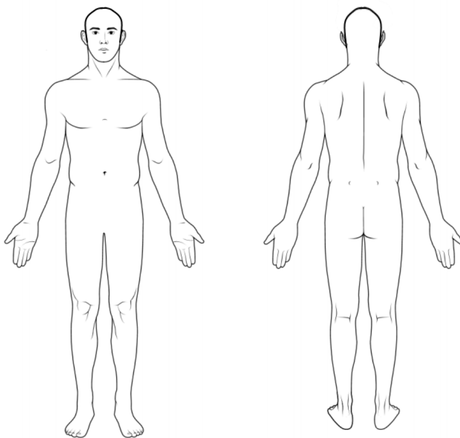
Emergency Contact: ______________________________________ Phone: (______)_________-_____________

Employer Name: ____

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

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
❒Rheumatoid arthritis
❒Heart problems
❒Previous stroke
❒Blood pressure issues
❒Pregnant
❒Fibromyalgia
❒Diabetes
❒History of falls with injury
❒Allergy to latex or medications *(list)* _________ _______________________

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:*