1113780

HILLCREST HEALTHCARE SYSTEM
TULSA, OKLAHOMA 74104

PATIENT DATA FORM
HMC3780 (02/12)

Patient Name:	Age	Sex	Date

Physician	Date of next Dr. Appt	Onset of Injury	Date of surgery

Occupation:	Are you working currently? Y N If no, why:

Please describe the problem you are having:

Have you had this problem before? Y N
If yes, when?

What makes it better? What makes it worse?

How do your symptoms affect your daily activities?

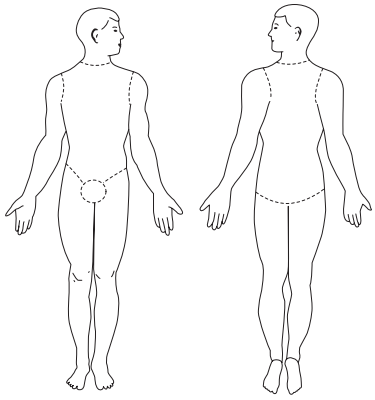
Does your current problem affect your ability to work? Y N If yes, how?

What can we help you do better through therapy?/ What is your goal?

Present Symptoms and Location

Symptom	Location
Pain	
Numbness/Tingling/Burning	
Stiffness	
Weakness	
Headaches	
Other	

☐ Dizziness ☐ Loss of Balance ☐ Nausea
☐ Difficulty swallowing ☐ Difficulty speaking ☐ Memory issues
☐ Double vision ☐ Ringing in ears ☐ Low Endurance



Indicate area(s) of symptoms on drawing:

X-pain
//=numbness or tingling

Pain rating: please rate your pain on a scale from 0-10 with 0 being no pain and 10 worst possible pain

Body part:	Current Rating	At Best	At Worst

In what type of home do you live:
☐ House ☐ Apartment - which floor _____
☐ Assisted living ☐ Nursing home
☐ Other:_____

Whom do you live with:
☐ Alone ☐ Spouse ☐ Significant other
☐ Personal care attendant ☐ Children: how many_____
☐ Pets: how many/ what kind_____
☐ Other:_____

Does your home have:
☐ Stairs: how many_____ ☐ With rails ☐ Without rails ☐ Ramps ☐ Uneven terrain ☐ Other:_____

Do you use:
☐ Single Point Cane ☐ Quad Cane
☐ Walker: ☐ No wheels ☐ Two wheels ☐ 4 wheeled walker
☐ Manual wheelchair ☐ Electric Wheelchair
☐ Other:_____

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Medical History:

☐ Allergies ☐ Arthritis (Osteoarthritis/ Rheumatoid) ☐ Blood Disorders ☐ Bowel/ Bladder Incontinence
☐ Broken bones/ Fractures ☐ Cancer: _____ ☐ Congestive Heart Failure ☐ Circulation/ Vascular Disease
☐ Depression/ Anxiety ☐ Developmental/ growth problems ☐ Diabetes/ High Blood Sugar ☐ Head injury/ Concussion
☐ Heart Attack ☐ High Blood Pressure ☐ Kidney Problems ☐ Infectious Diseases (TB, HIV, MRSA, VRE)
☐ Liver Disease/ Hepatitis ☐ Low blood sugar ☐ Neurological Condition ☐ Lung problems (COPD, Asthma)
☐ Osteoporosis ☐ Pacemaker/ Defibrillator ☐ Parkinson's Disease ☐ Repeated infections
☐ Seizures/ Epilepsy ☐ Skin Diseases ☐ Sleep Apnea ☐ Stroke
☐ Thyroid problem ☐ Ulcers/ Stomach problems (Reflux, Colitis, Hernia) ☐ Other: _____

Have you experienced any of the following in the past 6 months:

☐ Bowel/ Bladder problems ☐ Chest Pain ☐ Coordination Difficulties ☐ Cough x3 wks+ ☐ Coughing up blood ☐ Sleep disturbance
☐ Difficulty swallowing ☐ Difficulty walking ☐ Dizziness/ Blackouts ☐ Fever/ Chills ☐ Night sweats ☐ Pain at night
☐ Hearing problems ☐ Heart palpitations ☐ Joint pain/ swelling ☐ Loss of appetite ☐ Unexpected wt loss/ gain ☐ Loss of balance
☐ Nausea/ Vomiting ☐ Headaches ☐ Shortness of breath ☐ Vision changes ☐ Weakness in arms or legs ☐ Other: _____

Have you had any medical tests in the past year:

☐ Angiogram ☐ Arthroscopy ☐ Biopsy ☐ Blood Tests ☐ Bone Scan ☐ CT Scan ☐ Doppler Ultrasound
☐ Echocardiogram ☐ EKG ☐ EEG ☐ EMG ☐ Mammogram ☐ MRI ☐ Myelogram
☐ NCV (nerve conduction velocity) ☐ Pap smear ☐ Positive TB Test ☐ Spinal Tap ☐ Pulmonary Function Test ☐ Stool Test
☐ Stress Test ☐ Urine Test ☐ X- Ray ☐ Other: _____

Are you currently seeing any of the following clinicians:

☐ Acupuncturist ☐ Cardiologist ☐ Chiropractor ☐ Dentist ☐ Massage Therapist ☐ Neurologist ☐ Family Practitioner/ Internist
☐ Osteopath (D.O.) ☐ Podiatrist ☐ Rheumatologist ☐ Other: _____

Please list if you have had any surgeries or procedures:

Location/ Surgery Performed:	Date of Surgery:
1.	
2.	
3.	
4.	
5.	

Learning Assessment:

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Do you prefer to learn with: ☐ Verbal Instructions ☐ Written Instructions ☐ Pictures ☐ Hands On

Current Learning Barriers: ☐ None ☐ Communication ☐ Fatigue/ Pain ☐ Emotional ☐ Cultural ☐ Religious
☐ Cognitive ☐ Physical Disabilities ☐ Vision Deficit ☐ Hearing Deficit ☐ Other: _____

Advance Directive: Do you have an Advance Directive on File at HMC? Y N
If NOT, do you have an Advance Directive? Y N

This section to be completed by Clinician only: Summary List for Changes in Medical Diagnosis/Condition, Operative Procedures, & Allergies

Clinician: Complete this section only if there has been any medical diagnosis/condition/allergy change or operative procedure done since last visit.

Date:	Explain Medical Update:	Clinician Signature: