OSTEOPATHIC SPORTS WELLNESS INSTITUTE

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NEW PATIENT INTAKE FORM

To help us establish you with our practice, please provide us with your complete health history.

Name:_____ **Date:**__/__/__ **Date of Birth:** ___/___/___ **Age:**____ **Sex:** □M □F

Main Problems or Reasons for Appointment: (Please rank in terms of importance to you)

1._____

2._____

3._____

*Note: we may not be able to address every problem during this visit

When did these problems begin?

_____

_____

_____

Since these problems began, have they:

□Worsened □Improved □Stayed the same

Is there anything that improves the problem or pain?

_____

_____

_____

Is there anything that worsens the problem or pain?

_____

_____

_____

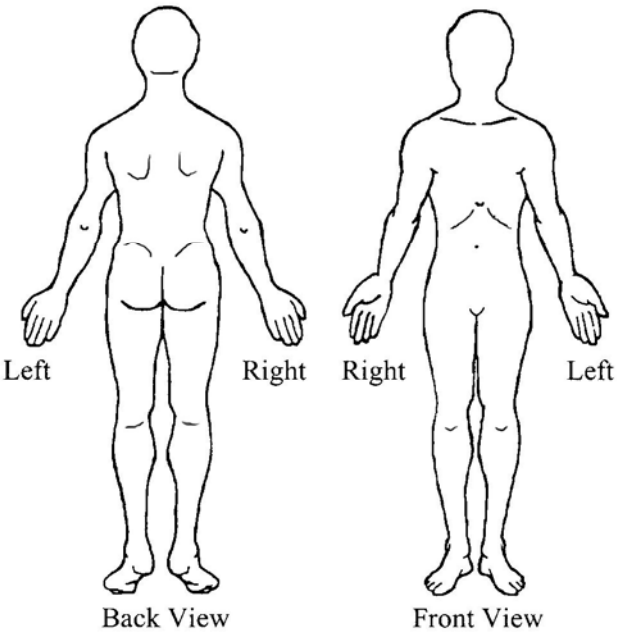
Are there other symptoms you experience with these problems? _____

_____

_____

Locate your pain on the figures below, using the symbols given below.

Ache ▲▲▲ Numbness ==== Pins/Needles ○○○ Burning xxxx Stabbing //// Other ●●●



Please rate your pain since your last visit on the scale below with W=Worst pain level, B=Best pain level, C=Current pain level "0" = No Pain and "10" = Worst possible pain

□ □ □ □ □ □ □ □ □ □ □

0 1 2 3 4 5 6 7 8 9 10

Past & Current Medical Problems:

Diagnosis	Month/Year First Diagnosed

Past Surgeries, Procedures & Hospitalizations:

Reason/Procedure	Month/Year

.

Current Medications: (Include regular meds, herbs, vitamins, other supplements)

Name of Med. Strength(mg) How many/day Reason for taking

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: (Include Medications, Food, Chemical, and Environmental)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Trauma History: (Include accidents, falls, broken bones, or loss of consciousness)

What Happened Date Age Were you hospitalized

_____
_____
_____
_____
_____
_____

Social History:

Education level:_____ Marital status (circle): Single Married Divorced Widowed

Number of children/dependents:_____ Ages/Sex:_____

Employer:_____ Type of Work:_____

Are you currently on disability: □Yes □No If so, why:_____How long:_____

Tobacco Use: □Yes □No How much/day:_____ How long:_____ I want to quit: □Yes □No

Alcohol Use: □Yes □No How much/day:_____ How long:_____ I want to quit: □Yes □No

Caffeine Use: □Yes □No How much/day:_____ How long:_____ I want to quit: □Yes □No

Do you follow a particular diet? □Yes □No What type:_____ How long:_____

Do you exercise regularly? □Yes □No What type:_____ How often:_____

Family History (Indicate any significant illness or disease that runs in your family)

Illness/Disease Relationship to you Living Age or Age at death

.

_____

_____

_____

_____

Patient Name:_____

Review of Systems Please mark any symptoms you have experienced in the last month. If not marked it is considered negative or non-pertinent.

Constitutional
- ❑ Appetite, excessive
- ❑ Appetite, poor
- ❑ Chills
- ❑ Fatigue
- ❑ Fevers
- ❑ Insomnia

Head
- ❑ Dizziness
- ❑ Grinding Teeth
- ❑ Headache
- ❑ Jaw Pain or Click
- ❑ Tooth Pain

Eyes
- ❑ Blurred Vision
- ❑ Floaters or Spots
- ❑ Vision Change
- ❑ Vision Loss

ENT
- ❑ Ear Pain
- ❑ Hearing Loss
- ❑ Ringing or Buzzing
- ❑ Nosebleed
- ❑ Sinus Pain
- ❑ Sinus Congestion
- ❑ Sinus Infection
- ❑ Change in Taste
- ❑ Dry Mouth
- ❑ Sore Throat
- ❑ Trouble Swallowing

Cardiovascular
- ❑ Blood Clots
- ❑ Chest Pain
- ❑ Short of Breath with Activities
- ❑ Irregular Heartbeat
- ❑ Lightheaded
- ❑ Swelling Feet

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cough
- ❑ Frequent Colds
- ❑ Pneumonia
- ❑ Short of Breath
- ❑ Wheezing

Gastrointestinal
- ❑ Bleeding
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn/Reflux
- ❑ Indigestion
- ❑ Nausea
- ❑ Ulcer
- ❑ Vomiting
- ❑ Bloody or Dark Stools
- ❑ Loss of Bowel Control

Musculoskeletal
- ❑ Broken Bones
- ❑ Difficulty Standing
- ❑ Difficulty Sitting
- ❑ Difficulty Walking
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Morning Stiffness
- ❑ Muscle Cramps
- ❑ Muscle Weakness
- ❑ Numb Hands/Fingers
- ❑ Numb Feet/Toes

Neuro/Psych
- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty Falling Asleep
- ❑ Difficulty Staying Asleep
- ❑ Fainting
- ❑ Head Injury
- ❑ Loss of Consciousness
- ❑ Loss of Sensation
- ❑ Poor Balance
- ❑ Poor Coordination
- ❑ Seizures
- ❑ Tingling Sensation
- ❑ Tremor or Shakes

Skin
- ❑ Dry
- ❑ Itchy
- ❑ Rashes

Genitourinary

-Urination that is:
- ❑ Bloody
- ❑ Burning
- ❑ Frequent
- ❑ Painful

- ❑ Kidney Stones
- ❑ Loss of Urinary Control
- ❑ Wake Up to Urinate

Reproductive
- ❑ Infertility
- ❑ Pain with Sex
- ❑ Erection Problems
- ❑ Pelvic Pain
- ❑ Painful Periods
- ❑ Hot Flashes

___# of Pregnancies

___# of Live Births

___Age Periods Began

___Age Menopause Began

Immune/Endocrine
- ❑ Anemia
- ❑ Easy Bruising
- ❑ Frequent Infections
- ❑ High / Low Blood Sugar
- ❑ Hypothyroid
- ❑ Hyperthyroid
- ❑ Hot Flashes
- ❑ Swollen Lymph Nodes
- ❑ Weight Gain / Loss

Tests/Studies

Please indicate where and when (month/year) you had any of the following tests done for the appropriate region.

Anatomy/**Procedure**	**X-ray**	**MRI**	**CT Scan**	**Bone Scan**	**EMG**
Head/Brain					
Cervical					
Thoracic					
Lumbar					
Chest					
Upper Extremity					

.

Lower Extremity					
Abdomen					
Pelvis					
Other					

YOUR PRIMARY CARE DOCTOR'S NAME: _____

DR's PHONE #_____

YOUR PRIMARY CARE DOCTOR'S ADDRESS:

_____

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? ☐Yes ☐No

This history record has been designed to facilitate our patient's continuity of care at Osteopathic Sports & Wellness Institute, Inc. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

_____ _____

Patient/Guardian signature who filled out the history **Date**

_____ _____

Physician Signature **Date**