Healthcare Excellence
Collaborative Health Specialty Services

Behavioral Health
Endocrinology | Diabetes
Osteopathic Manipulative Medicine
Sports Medicine
Physical Medicine & Rehabilitation

New Patient History Form-ONMM

Please fill out this form in its entirety and bring it to your initial visit along with any x-rays, CT scans, MRIs or other tests. Please arrive **15-20 minutes early** for your appointment.

PERSONAL HEALTH HISTORY

Date of Birth: _____

Name: _____

Last First Middle

Primary Care Provider: _____

Name Address Phone/Fax

How did you hear about our clinic? _____

HISTORY OF CHIEF COMPLAINT

Why are you being seen today? _____

Have you had previous episodes of this complaint? Y or N

When was the first episode of this complaint? _____

How many previous episodes of this complaint have you had in the past two years? _____

SEVERITY *(circle the following)*

Overall the pain is: improving not changing worsening

What is your LEAST pain? 0 1 2 3 4 5 6 7 8 9 10

What is your WORST pain? 0 1 2 3 4 5 6 7 8 9 10

What is your AVERAGE pain? 0 1 2 3 4 5 6 7 8 9 10

LOCATION OF COMPLAINT *(circle/list the following – indicate pain level 0-10 beside each complaint)*

(R=right L=left B=both)

Neck – R L B /10	Elbow – R L B /10	Hip – R L B /10
Mid back – R L B /10	Wrist – R L B /10	Thigh – R L B /10
Lower back – R L B /10	Hand – R L B /10	Knee – R L B /10
Head (location): _____ /10	Finger: _____ /10	Leg – R L B /10
Face – R L B /10	Chest – R L B /10	Calf – R L B /10

Jaw – R L B /10 | Foot – R L B /10 | Ankle – R L B /10

Shoulder – R L B /10 | Abdomen: _____ /10 | Toe: _____ /10

Arm – R L B /10 | Pelvic region – R L B /10 | Other: _____ /10

Forearm – R L B /10 | Groin – R L B /10

DATE OF INJURY

Injury occurred on: _____

CURRENT PAIN CAUSED BY *(circle the following)*

Twisting Pushing/Pulling Bending Trauma Lifting Car accident Recreation/sports Work related

Non-work related Fall Overuse Degenerative process Unknown Other: _____

QUALITY OF PAIN *(circle the following)*

Sharp Dull Throbbing Aching Periodic Intermittent Occasional Constant

Does it wake you up at night? Y or N If yes: While lying still Changing positions Both

Pain throughout the day: Increase Decrease Stays the same

Pain/stiffness when getting out of bed? Y or N

Radiating to: Right arm Left arm Right leg Left leg

ACTIVITIES THAT INCREASE PAIN (circle the following and indicate which body part is affected)

Sitting Bending over & standing up Lying down Walking Up/down stairs Reaching overhead

Reaching forward Reaching back Reaching across Talking Chewing Yawning Sports/recreation

Repetitive activity Household activity Standing Squatting Sleeping Coughing

Other: _____

ACTIVITIES THAT RELIEVE PAIN *(circle the following and indicate which body part is affected)*

Sitting Heat Cold Stretching Wearing a splint or orthotics Rest Standing Walking Exercise

Lying down Massage Medication Nothing Other: _____

TREATMENT SUCCESS *(circle the following)*

Freedom from all pain Doing all desired activities Any amount of pain relief Tolerating simple activities

FUNCTIONAL LEVEL *(circle the following)*

Physical activity at work or school: Sitting Standing Phone use Lifting (repeated or heavy) Computer use

PREVIOUS TESTING *(Circle no testing or list all previous tests you have had related to your symptoms)*

No testing.

(X-ray, MRI, CT scan, Myelogram, Discogram, Bone scan, DEXA, Nerve conduction study, EMG, blood work)

	Test	*Body Area*	*Approximate Date*	*Results*
1.				
2.				
3.				
4.				
5.				

PRIOR TREATMENT *(circle no prior treatment or list the practitioners you have seen for this problem along with the approximate dates of those visits)*

No prior treatment.

	Name	*Location*	*Approximate Date*
1.			
2.			
3.			
4.			
5.			
6.			

PAST TREATMENTS *(please circle)*

No past treatments.

Stretching Ultrasound Heat Ice Massage Electrical Stimulation Physical therapy Strengthening

Traction Bed rest Chiropractic manipulation Osteopathic manipulation Injection Brace Acupuncture

Anti-inflammatory Narcotics Muscle relaxant Anti-depressant medication

OMM FUNCTION INDEX *(circle or list the following)*

Do you require help lifting? Y or N

Is your sitting generally limited to less than 30 minutes? Y or N

Is traveling in a vehicle generally limited to less than 30 minutes? Y or N

Is standing in one place generally limited to less than 30 minutes? Y or N

Is your walking generally limited to less than 30 minutes? Y or N

Do you regularly curtail or miss social activities due to pain? Y or N

Are you able to do all of activities of daily living yourself? (like bathing, dressing, etc.) Y or N

Please list those you cannot perform: _____

Do you participate in any housework? (laundry, cooking, cleaning, etc.) Y or N

If so, what chores? _____

PREVIOUS INJURY HISTORY

Please list any previous injuries you have had in your entire life. How and when the injury occurred.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

REVIEW OF SYSTEMS *(circle the following)*

1) General Symptoms:	fever, chills, night sweats, weight change, change in diet/appetite, lethargy/fatigue
2) Eyes/Visual:	pain in or around the eyes, sensitivity to light, blurred vision, seeing double images, visual disturbances
3) Head:	recent injury, pain, tenderness
4) Ears:	pain, ringing, discharge, decreased hearing
5) Nose:	sinus pain, nasal congestion/discharge, nasal discharge: blood
6) Mouth & Throat:	pain, sores, teeth grinding, TMJ clicking/grinding or pain
7) Cardiovascular:	high blood pressure, chest pain, extremity swelling, palpitations
8) Respiratory:	cough, wheezing, snoring, shortness of breath, daytime sleepiness
9) Gastrointestinal:	nausea, vomiting, abdominal pain, change in bladder/bowel habits, constipation, diarrhea, fecal incontinence
10) Genitourinary:	bladder changes, genital discharge, urinary incontinence, pelvic pain
11) Musculoskeletal:	stiffness, bone/joint swelling, joint pains, muscle cramps, muscle weakness
12) Skin:	rash, suspicious lesion on skin, skin changes noted, skin itching, dry skin, birthmark on spine

13) Neurological: paralysis, headaches, weakness, fainting, numbness, tingling, transient loss of speech or vision, memory loss, vertigo/dizziness, spasticity, tremors
14) Psychiatric: anxiety, depression, confusion, irritability
15) Endocrine: cold/heat intolerance, tiredness, weight change, increased thirst, increased hunger, increased urination
16) Hematologic: easy bruising, swollen glands, bleeding, tender lymph nodes
17) Allergy: medication allergy, seasonal allergy, environmental allergy, hives

PHARMACY

Primary: _____

Secondary: _____

ALLERGIES

Do you have any medication, food, or environmental allergies? Y or N

If yes, please list each allergy and your reaction: _____

_____

MEDICATIONS

Please list all medications and supplements (prescription and non-prescription) that you take now or as needed.

Medication	*Dose/frequency*	*Medication*	*Dose/frequency*
1. _____		6. _____	
2. _____		7. _____	
3. _____		8. _____	
4. _____		9. _____	
5. _____		10. _____	

FAMILY HEALTH HISTORY

Choose from the following relationships: (Mother, Father, Sister, Brother, Daughter, Son, Maternal-Aunt/Uncle, Maternal-Grandmother/Grandfather, Paternal-Aunt/Uncle, Paternal-Grandmother/Grandfather)

Condition	***Relationship***	***Condition***	***Relationship***	***Condition***	***Relationship***
Cancer	_____	Ulcers	_____	Bleeding Problems	_____
Obesity	_____	Stomach/bowel	_____	Anemia	_____

High BP _____	Gout _____	Rheumatic Fever_____
Heart Trouble _____	Kidney Disease _____	Alcoholism _____
Stroke _____	Arthritis _____	Mental Illness _____
Asthma _____	Nerve disease _____	Physical Deformity_____
Allergies _____	Muscle disease _____	Blind/Deaf _____
Diabetes _____	Seizures _____	Hereditary Problems_____
Death by Accident _____	Other _____	

SOCIAL HISTORY

Substance Use (circle or list the following)

Do you or have you ever smoked tobacco? Y or N If previously quit, when? _____

What is your level of alcohol consumption? _____ Do you use any illicit or recreational drugs? Y or N

What is your level of caffeine consumption? _____

Education and Occupation (circle or list the following)

Are you currently employed? Y or N What is your occupation? _____

Previous Activities/Sports/Hobbies _____

Current Activities/Sports/Hobbies_____

PAST SURGICAL HISTORY *(Include all surgeries/procedures/dental work including fillings and crowns)*

Procedure	*Date*	*Procedure*	*Date*

PAST MEDICAL HISTORY List all providers you see/have seen, and the current/past condition.

(Example: Neurology, Gastroenterology, OB/Gyn, Oncology, etc.)

Specialist	*Condition Treated*