LIFE IN BALANCE
OSTEOPATHIC MEDICAL CENTER, PLLC

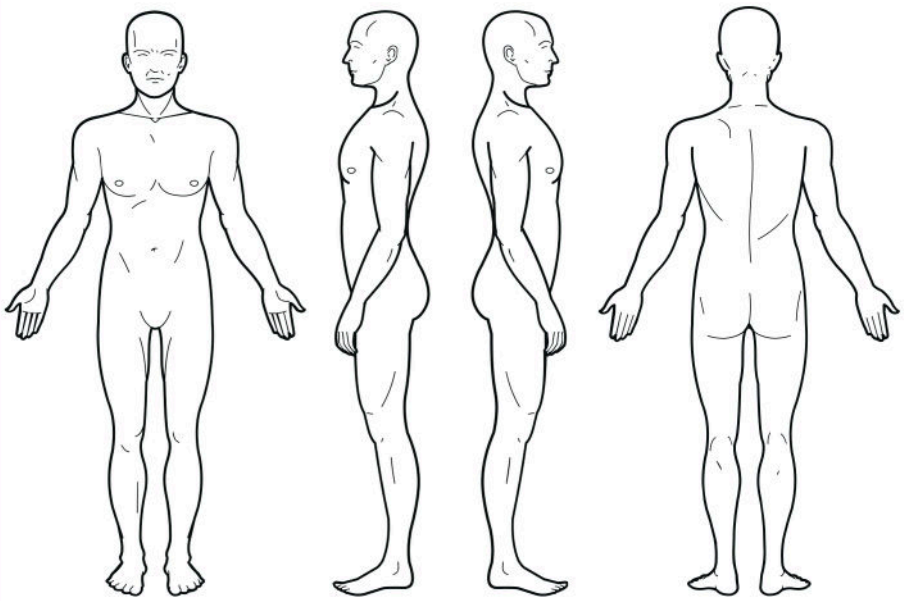
NEW PATIENT HISTORY FORM

PATIENT NAME: _____ DOB: _____

OCCUPATION: _____ DATE: _____

PAIN LOCATION

Circle area of **WORST** pain. Mark other pain areas with "X."



WHAT BRINGS YOU IN TODAY?

_____

_____

_____

_____

WHEN DID PAIN BEGIN?

_____

SEVERITY OF YOUR PAIN

On a scale of 1–10 (0=no pain; 10=the worst)

Level currently? _____ /10

Level at best? _____ /10

Level at worst? _____ /10

REGARDING YOUR PAIN, CHECK ALL THAT APPLY:

HOW DID THE PAIN BEGIN?

- ☐ Work related accident
- ☐ Motor vehicle accident
- ☐ Fall
- ☐ Post surgical
- ☐ Post interventional procedure
- ☐ Other _____

DESCRIBE YOUR PAIN

- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Other _____
- ☐ Dull
- ☐ Aching
- ☐ Spasm
- ☐ Tight

DOES THE PAIN AFFECT YOUR:

- ☐ General activity
- ☐ Mood
- ☐ Walking ability
- ☐ Work routine
- ☐ Sleep
- ☐ Enjoyment of life
- ☐ Concentration
- ☐ Appetite
- ☐ Relationships
- ☐ Other _____

WHAT MAKES THE PAIN WORSE?

- ☐ Lifting
- ☐ Bending
- ☐ Twisting
- ☐ Sitting
- ☐ Other _____
- ☐ Standing
- ☐ Driving
- ☐ Lying down
- ☐ Walking

WHAT MAKES THE PAIN BETTER?

- ☐ Exercise
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Other _____
- ☐ Medication
- ☐ Ice
- ☐ Heat
- ☐ Nothing

What services are you interested in? Injection Therapy, OMT, Nutrition, Stress Management, etc.

_____

Have you ever had a severe accident/injury? If so, when? Please explain. _____

_____

_____

How did you hear about Life in Balance/Referral? _____

PATIENT NAME: _____ DOB: _____

DATE: _____

PREVIOUS TREATMENTS

HAVE YOU BEEN EVALUATED BY:

- ☐ Osteopathic Physician
- ☐ Orthopedic Surgeon
- ☐ Spine.Surgeon
- ☐ Neurosurgeon
- ☐ Physical Medicine (PMR)
- ☐ Neurologist
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist (PT)
- ☐ Chiropractor

ORTHOPEDIC PROCEDURES/ INTERVENTIONS

- ☐ Cervical fusion
- ☐ Vertebroplasty
- ☐ Kyphoplasty
- ☐ Lumbar laminectomy w/wo fusion
- ☐ Shoulder/rotator cuff repair/tenodesis
- ☐ Carpal tunnel release
- ☐ Total hip/knee arthroplasty (THA/TKA)
- ☐ Radiofrequency ablation (RFA)
- ☐ Other: _____

OTHER SURGICAL HISTORY

- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Gallbladder removal
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ Bypass (CABG)
- ☐ Angioplasty w/wo stent
- ☐ Pacemaker/defibrillator
- ☐ C-Section
- ☐ Other: _____

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH:

- ☐ Cervical (neck) trauma
- ☐ Known coagulation defect
- ☐ Inflammatory spondylopathy
- ☐ Osteoporosis
- ☐ Aortic aneurysm/dissection

PREVIOUS INJECTION THERAPY

- ☐ Platelet Rich Plasma (PRP)
- ☐ Perineural Injection Treatment (PIT)
- ☐ Prolotherapy
- ☐ Epidural steroid INJ
- ☐ Facet INJ (cervical/thoracic/lumbar)
- ☐ Sacroiliac joint INJ
- ☐ Trigger point INJ
- ☐ Shoulder/hip/knee INJ
- ☐ Steroid INJ
- ☐ Synvisc/MonovisINJ
- ☐ Tenotomy/dry needling
- ☐ Other

ANYTHING ELSE:

_____

_____

_____

MEDICATION *"C" = Currently taking; "T"= Tried & failed in the past*

PAIN RELIEVER/NSAIDs:

- ___ Tylenol (Acetaminophen)
- ___ Motrin (Ibuprofen)
- ___ Aleve (Naproxen)
- ___ Mobic (Meloxicam)
- ___ Celebrex (Celecoxib)
- ___ Voltaren Gel (Diclofenac)
- ___ Other

MUSCLE RELAXER:

- ___ Flexeril (Cyclobenzaprine)
- ___ Robaxin (Methocarbamol)
- ___ Norflex (Orphenadrine)
- ___ Zanaflex (Tizanidine)
- ___ Soma (Carisoprodol)
- ___ Baclofen

NERVE MEDICINE:

- ___ Neurotin (Gabapentin)
- ___ Lyrica (Pregabalin)

BENZODIAZEPINES:

- ___ Valium (Diazepam)
- ___ Ativan (Lorazepam)
- ___ Klonopin (Clonazepam)

ANTI-DEPRESSANTS (SSRI/SNRI/TCA):

- ___ Prozac (Fluoxetine)
- ___ Effexor (Venlafaxine)
- ___ Celexa (Citalopram)
- ___ Lexapro (Escitaloram)
- ___ Elavil (Amitriptyline)
- ___ Cymbalta (Duloxitine)
- ___ Nortriptyline

SLEEP MEDICINE:

- ___ Ambien (Zolpidem)
- ___ Lunesta (Eszopiclone)
- ___ Restoril (Temazepam)
- ___ Rozarem
- ___ Melatonin
- ___ Trazodone

NARCOTICS/OPIATES/OPIOIDS:

- ___ Duragesic (Fentanyl)
- ___ Dilaudid (Hydromorphone)
- ___ Ultram (Tramadol)
- ___ Methadone
- ___ Norco/Lortab (Hydrocodone)
- ___ Oxycontin/Percocet (Oxycodone)
- ___ Suboxone
- ___ Low Dose Naltrexone

PREFERRED PHARMACY LOCATION

_____

_____

_____

FOOD OR DRUG ALLERGIES:

_____

_____

_____

LIST OTHER MEDS (WITH STRENGTH) *INC. OVER-THE-COUNTER, SUPPLEMENTS, VITAMINS, ETC.*

_____

_____

PATIENT NAME: _____ DOB: _____

DATE: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

CONSTITUTIONAL *(CIRCLE WHICH)*
- ☐ Fevers/chills/fatigue/night sweats
- ☐ Loss of appetite
- ☐ Unintentional weight loss/gain
- Insomnia

EYES/EARS/NOSE/THROAT
- ☐ Headaches/visual disturbances
- ☐ Sore throat
- ☐ Difficulty swallowing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Difficulty breathing when you lie down
- ☐ Difficulty breathing that wakes you

GASTROINTESTINAL
- ☐ Nausea/vomiting/diarrhea
- ☐ Abdominal pain/constipation
- ☐ Bloody stools

RESPIRATORY
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood

GENITOURINARY
- ☐ Urinating at night
- ☐ Urinating too much
- ☐ Incontinence

MUSCULOSKELETAL
- ☐ Loss of bowel or bladder function
- ☐ Chronic low back pain
- ☐ Joint pain

NEUROLOGIC
- ☐ Issues with balance
- ☐ Weakness
- ☐ Numbness or tingling
- ☐ Pins & needles

HEMATOLOGIC/ENDOCRINE
- ☐ Excessive bleeding
- ☐ Bruising

PYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty concentrating
- ☐ Thoughts of self-harm
- ☐ Thoughts of violence
- ☐ PTSD

FEMALES
- ☐ Pelvic pain
- ☐ Discharge
- ☐ Pain with intercourse
- ☐ Abnormal periods
- ☐ Heavy bleeding
- ☐ Abnormal uterine bleeding

_____

_____

MEDICAL HISTORY

- ☐ High blood pressure — S M F BR SI
- Diabetes — S M F BR SI
- ☐ Heart Disease — S M F BR SI
- Thyroid disease — S M F BR SI
- ☐ Kidney disease — S M F BR SI
- Liver disease/hepatitisI — S M F BR SI
- ☐ Lung disease/COPD — S M F BR SI
- Cancer Where? _____ — S M F BR SI
- ☐ Autoimmune Condition — S M F BR SI
- Spine Problems — S M F BR SI
- ☐ Other _____ — S M F BR SI

KEY	
S	Self
M	Mother
F	Father
BR	Brother
SI	Sister

SOCIAL HISTORY

Tobacco use: ☐ Yes ☐ No ☐ Previously Used
How much? _____ Quit date? _____

THC/Cannabis use: ☐ Yes ☐ No ☐ Previously Used
How much? How often?

Alcohol use: ☐ Yes ☐ No
Drinks per week/month? _____

Illicit drug use: ☐ Yes ☐ No ☐ Previously Used
What? How much?

Caffeine use: How much per day? _____

Exercise:
Type _____ How often? _____

Fruits/Vegetables Intake: Servings per day? _____

Water Intake: Ounces per day?

DR. GRUBER MAY BE USING DICTATION IN HER EVALUATIONS/SESSIONS. IS THIS OKAY? ☐ *YES* ☐ *NO*

PATIENT SIGNATURE DATE PHYSICIAN REVIEWED DATE