LIFE IN BALANCE
OSTEOPATHIC MEDICAL CENTER, PLLC

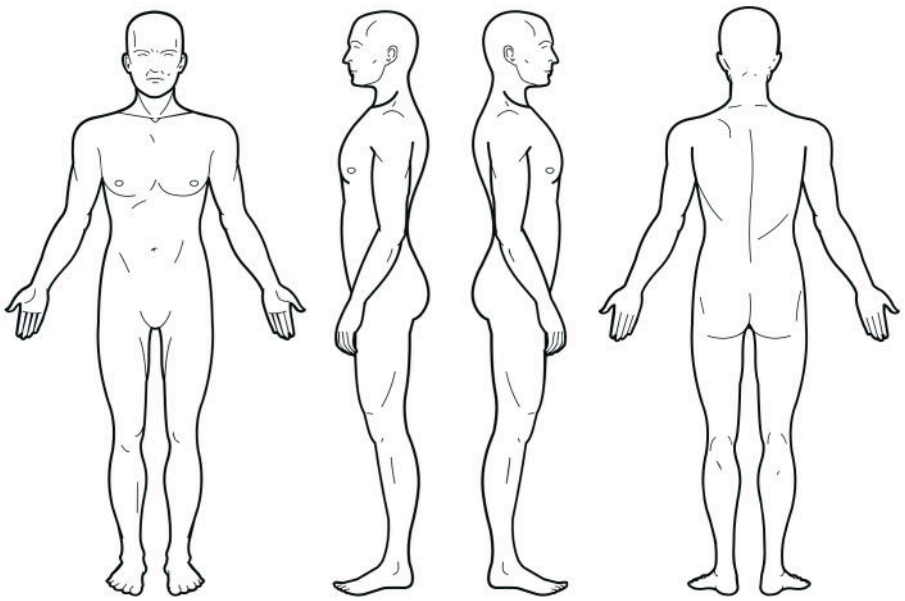
# NEW PATIENT HISTORY FORM

PATIENT NAME: _____ Age _____ 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
- ☐ Dull
- ☐ Aching
- ☐ Spasm
- ☐ Tight
- ☐ Other _____

### 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
- ☐ Standing
- ☐ Driving
- ☐ Lying down
- ☐ Walking
- ☐ Other _____

### WHAT MAKES THE PAIN BETTER?

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

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 cuf repair/tenodesis
- ☐ Carpal tunnel release
- ☐ Total hip/knee arthroplasty(THA/TKA)
- ☐ Radio-frequency 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 Treatmen (PIT)
- ☐ Prolotherapy
- ☐ Epidural steroid INJ
- ☐ Facet INJ (cervical/thoracic/lumbar)
- ☐ Sacroiliac joint INJ Trigger point INJ
- ☐ Shoulder/hip/knee INJ Steroid INJ
- ☐ Steroid INJ
- ☐ Synvisc/MonovisINJ
- ☐ Synvisc/MonovisINJ
- ☐ Tenotomy/dry needling
- ☐ Other

ANYTHING ELSE:

_____

_____

_____

## 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

_____

_____

PATIENT NAME: _____ DOB: _____

## 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

_____

_____

OFFICE STAFF: GR

FOOD OR DRUG ALLERGIES:

_____

_____

_____

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

_____

_____

## MEDICAL HISTORY

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

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?

WHEN WE OBTAIN PAYMENT FOR SERVICES, MAY WE KEEP YOUR CREDIT CARD ON FILE *YES* *NO*

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

PATIENT SIGNATURE DATE PHYSICIAN REVIEWED DATE