Restoration
OSTEOPATHIC MEDICINE

New Patient History Form

Using a black or blue pen, please write clearly and answer **ALL** questions by filling out the appropriate box(es).

Name:		Today's Date:
Date of Birth:	Gender (circle): Male Female Undifferentiated	Height: Weight:
Primary Care Provider:		Clinic/Location:

Current Medications/Supplements:

_____ By initialing, I authorize Restoration Osteopathic Medicine to obtain my medication history from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

☐ **I am not taking any prescribed medications or over-the-counter supplements/vitamins.**

Medication	Dose	How many times per day?

Allergies:

☐ **I have no known allergies to prescribed medications or medical supplies.**

Medication	Reaction

Surgical History:

Please list any previous surgeries. ☐ **NONE**

Surgery	Date

Medical History:

Please indicate whether you have or have had any of the following by filling in the appropriate box(es). ☐ **NONE**

General:
☐ COPD
☐ High Blood Pressure
☐ Diabetes
☐ Myocardial Infarction (MI)
☐ Stroke
☐ Arthritis
☐ Migraine
☐ Asthma
☐ Heart Failure (CHF)
☐ Irregular Heartbeat

Allergy:
☐ Hay Fever
☐ Other_____

Cancer:
☐ Skin (BCC, SCC or MM)
☐ Prostate
☐ Bladder
☐ Thyroid
☐ Bone
☐ Lung
☐ Colon

Circulatory/Cardiovascular:
☐ Aneurysm
☐ DVT
☐ Pacemaker
☐ Atrial Fibrillation
☐ Varicose Veins

Dermatologic:
☐ Eczema
☐ Psoriasis

Digestive/Gastrointestinal:
☐ Gallbladder Disease
☐ Liver Disease
☐ Colitis
☐ GERD
☐ Hepatitis B or C (Circle)

Ears:
☐ Vertigo
☐ Hearing Problem

Endocrine:
☐ Endocrine Disorder
☐ Thyroid Disorder

Genitourinary:
☐ Kidney Disease
☐ Renal Dialysis
☐ Kidney Infection
☐ Renal Failure
☐ Urinary Disorder

Hematologic:
☐ Anemia
☐ Blood Disorder
☐ Taking Blood Thinners

Infectious:
☐ Tuberculosis
☐ Lyme Disease
☐ HIV/AIDS

Musculoskeletal:
☐ Artificial Joint
☐ Hip Fracture
☐ Osteoarthritis
☐ Knee Disorder
☐ Fracture
Type: _____

Neurologic:
☐ Meningitis
☐ TIA
☐ Head Injury
☐ Traumatic Brain Injury
☐ Brain Disorder
☐ Multiple Sclerosis

Psychologic:
☐ Anxiety
☐ Depression
☐ Emotional Abuse
☐ Physical Abuse
☐ Attempt Suicide
☐ Psychiatric Disorder
☐ Schizophrenia
☐ Sexual Abuse

Respiratory:
☐ Sleep Apnea
☐ Chronic Lung Disease

☐ Other_____
☐ Other_____
☐ Other_____

Review of Symptoms

Please indicate whether you have or have had any of the following by filling in the appropriate box(es). ☐ **NONE**

General:
☐ Fatigue
☐ Weight Gain
☐ Weight Loss
☐ Weakness

Musculoskeletal:
☐ Restricted motion
☐ Muscle stiffness
☐ Swelling
☐ Joint Pain
☐ Joint Stiffness

Cardiovascular:
☐ Palpitations
☐ Chest Pain
☐ Swelling of Legs

Gastrointestinal:
☐ Abdominal Pain
☐ Nausea
☐ Diarrhea
☐ Heartburn

Psychiatric:
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Insomnia
☐ Nervousness

Neurological:
☐ Fainting
☐ Tingling
☐ Dizziness
☐ Numbness

Hematologic/Lymph:
☐ Easy Bruising
☐ Easy Bleeding
☐ Lumps
☐ Blood Clots

Respiratory:
☐ Cough
☐ Short of Breath
☐ Wheezing

Family History:

☐ **NONE, Family members are all healthy.**

☐ **No Known Family History**

Family Member	Disease/Disorder	Alive or Deceased

Social History:

Occupation:				
Employment Status:	☐ Full-time ☐Part-time ☐ Retired ☐Unemployed ☐ Disabled ☐Homemaker			
Exercise: ☐ NONE	Type: ☐ Flexibility ☐ Aerobic	Intensity: ☐ Light ☐ Moderate ☐ Vigorous	Duration: ☐ 0-30 mins ☐ 31-60 mins ☐ 1- 1.5 hrs	Frequency: ☐ Daily ☐ Weekly ☐ Monthly
Caffeine: ☐ NONE	Type: ☐ Coffee ☐ Tea ☐ Other_____	Cups (Daily): ☐ Less than 1 ☐ 1-2 ☐ 3-4		
Alcohol: ☐ NONE	Type: ☐ Beer ☐ Wine ☐ Liquor	Frequency: ☐ Social ☐ Light ☐ Occasional		
Smoking Status:	☐ Current every day smoker ☐Heavy tobacco smoker	☐Current some day smoker ☐Former	☐Light tobacco smoker ☐Never	
Nicotine products:	☐ Cigars ☐Pipe ☐E-Cigarette ☐Chewing Tobacco ☐Former ☐Never			
Drug use:	☐Current- Type: _____	☐Former- Type: _____	☐Never	

Imaging:

Please indicate if you have had any of the following imaging. ☐ **NONE**

Type	Area of Body	Date	Facility
Ultrasound			
X-Ray			
MRI Scan			

Chief Complaint - Primary Reason for Today's Visit:

Location of Pain:	**Does the pain radiate?** YES NO

Did an accident, event or trauma cause the pain? If so, when?	**How long has the pain been present?** Days?	Weeks?	Months?	Years?

Pain Scale:

Please circle your **CURRENT** pain level.

0	No pain.
1	You barely notice the pain.
2	You may feel some twinges of pain.
3	You notice the pain but can tolerate it.
4	You can ignore the pain at times.
5	Can't ignore the pain but still work through.
6	Pain makes it hard to concentrate.
7	Pain distracts you and limits your sleep.
8	Pain is so intense you have trouble talking.
9	Pain is so bad you can't even sleep or talk.
10	Worst pain you can imagine.

Describe your pain:

Please check the following descriptions of your **CURRENT** pain.

☐ Achy	☐ Numb	☐ Stabbing
☐ Burning	☐ Pinching	☐ Throbbing
☐ Cold	☐ Pounding	☐ Tender
☐ Cramping	☐ Pressure	☐ Tight
☐ Crushing	☐ Pulling	☐ Tingling
☐ Dull	☐ Sharp	☐ Other; please describe_____
☐ Gnawing	☐ Shooting	
☐ Heavy	☐ Sore	

Frequency:
- ☐ Continuous
- ☐ Intermittent
- ☐ Changes in severity but always present

Timing:
- ☐ Worse in the morning
- ☐ Worse in the afternoon
- ☐ Worse at night
- ☐ Constant (All Day)

Treatments/Therapies tried:

☐ **NONE**	☐ Posture Adjustment
☐ Physical Therapy	☐ Sit/Stand Desk
☐ Chiropractor	☐ Brace/Supportive Devices
☐ Massage	☐ Other_____

What makes the pain better?

☐ **Nothing**	☐ Standing	☐ Topical cream	☐ PT
☐ Activity	☐ Lying down	☐ NSAIDS	☐ Chiropractor
☐ Rest	☐ Heat	☐ Other medication	☐ Massage
☐ Sitting	☐ Ice	☐ Compression	☐ Other_____

What makes the pain worse?

☐ **Nothing**	☐ Standing
☐ Activity	☐ Sitting
☐ Rest	☐ Laying Down

Pain over time?	☐ Improved ☐ Worsened ☐ Stayed the Same	**How has the pain developed?**	☐ Improved function ☐ Increased ROM ☐ Decreased Pain	☐ No Change ☐ Worsened

Treatments Tried:

☐ **NONE**

Type:	When/For How Long?	Any Relief?
Physical Therapy		
Chiropractic		
Acupuncture/ Injections		
Injections		
Massage		
Medications (EX: Advil, Oxycodone, Flexeril, Prozac, Gabapentin, etc.)		