NEW PATIENT HISTORY FORM

OMT - Derek Rosol, DO

Welcome!

At the time of your first visit with Derek Rosol, DO, please bring with you these forms, completed in their entirety. Please also bring copies of any imaging (x-rays, CT scans, MRIs, or any other test results that are relevant to your visit), a list of your current medications and nutritional supplements, and your insurance card and photo ID.

PERSONAL HEALTH HISTORY:

Date: _____

Patient Name (First, Last, Middle Initial): _____

DOB: _____ Age: _____ Sex: ❒ Female ❒ Male

Height: _____ Weight: _____

Referring Physician:

Name: _____ Phone: (___) _____

Address: _____

Chief Complaint:

Why would you like to be seen? _____

_____

_____

_____

_____

_____

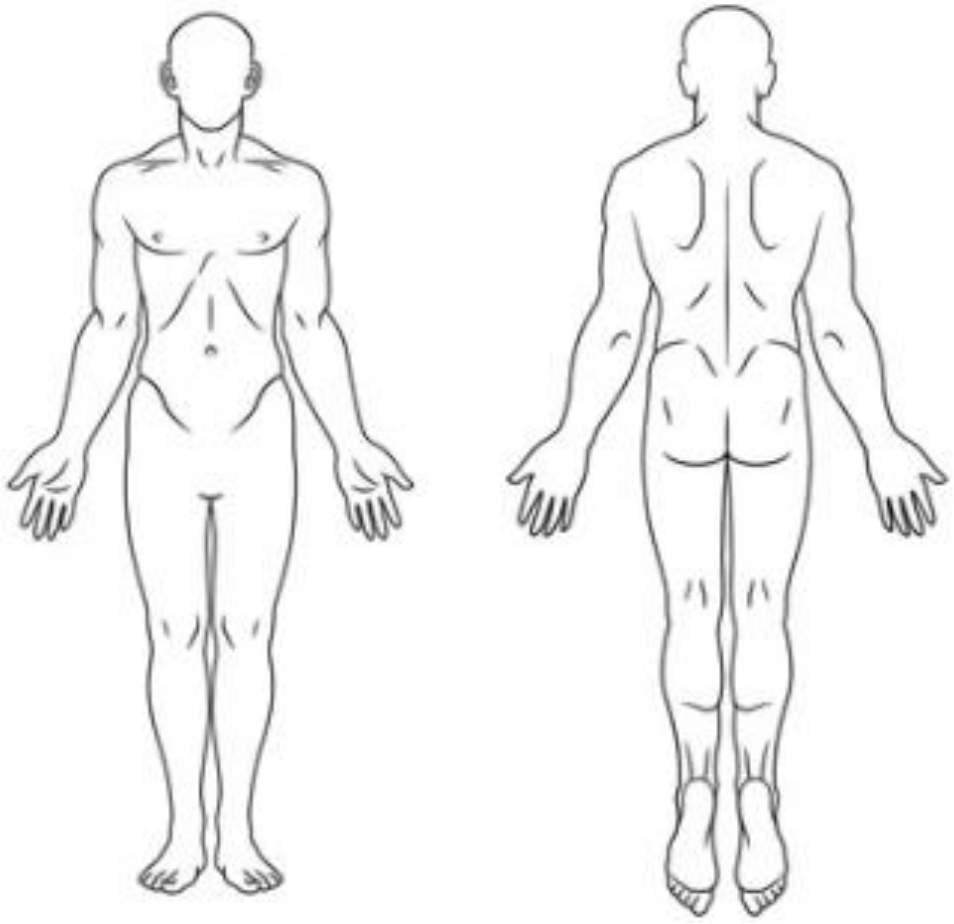
History of Chief Complaint:

When did *this* episode of pain or problem begin? _____

Do you have pain? ❒ Yes ❒ No
If yes, have you had previous episodes of this pain? ❒ Yes ❒ No
If yes, how long ago was your first episode of this pain? _____
About how many previous episodes of this pain have you had in the last two years? _____

Circle a number below to indicate the level of your pain (0 is the least and 10 is the worst):
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 daily pain rating? 0 1 2 3 4 5 6 7 8 9 10

Mark the area(s) on your body where you feel pain now with an X. Include all affected areas. Please note next to the X any aches, numbness, "pins & needles", burning, stabbing, etc.



If your pain is the result of an injury, please describe the incident and date of incident:

Date of Injury: _____

Please Describe: _____

_____

_____

_____

How did the current episode of pain occur? (check all that apply)

❒ Gradual onset
❒ Direct blow
❒ On-the-job injury
❒ Twisting
❒ Lifting
❒ Fall
❒ Pushing/Pulling
❒ Vehicle accident
❒ Bending
❒ Recreational accident
❒ Non-work related incident
❒ No known cause
❒ Other: _____
_____

List specific activities which increase your pain:

1. _____ 2. _____

3. _____ 4. _____

List specific methods or activities that relieve your pain:

1. _____ 2. _____

3. _____ 4. _____

How will you define treatment success?
❒ Freedom from all pain
❒ Doing all desired activities
❒ Any amount of pain relief
❒ Tolerating simple activities

Diagnostic Tests:
Which of the following diagnostic tests have been performed for your problem? Please indicate body area, approximate date(s), and results as you understand them. Please state if you have been unable to complete any of these tests, or have had a severe reaction to any of them:

Test: Body Area: Date: Results (as you understand them):
X-rays: _____
CT scan: _____
Myelogram: _____
MRI scan: _____
Discogram: _____
Bone Scan: _____
EMG: _____
Nerve Conduction: _____
Other: _____

Prior Treatment:
Please list the practitioners you have seen for this problem along with the approximate dates of those visits.

Type of Practitioner: Practitioner's Name: Location: Approximate Dates:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Prior Treatment Types:
Please put a check mark next to each type of treatment you have received for this problem, in the corresponding column that best describes the treatment outcome. If you have had treatments for this problem that are not listed, please note them at the bottom of the list and indicate how they affected you.

Type of Treatment:	**Helped:**	**Made Worse:**	**No Change:**
Stretching exercises			
Ultrasound			
Ice/Heat			
Massage			
Electrical Stimulation			
TENS unit for home use			
Physical Therapy			
Home Exercises			
Traction			
Bed Rest			
Chiropractic Treatment			
Osteopathic Manipulation			
Injection Therapy			
Brace			
Acupuncture			
Anti-inflammatory Medication			
Narcotic Pain Medication			
Muscle Relaxant Medication			
Anti-depressant Medication			
Surgery			

Other Treatments: _____

_____

Past Medical History:
When was your last regular medical examination? _____

Please list any history of past medical diagnoses or chronic medical problems that you are being treated for (Cancer, Diabetes, High Blood Pressure, etc.):

_____

_____

_____

_____

_____

Past Medical History:
Please list any surgeries or major dental procedures you have had and the approximate dates.

	Procedure:	Date:
1.		
2.		
3.		
4.		
5.		
6.		

Allergies:
Do you have allergies to any medications or food, or environmental allergies? ❒ Yes ❒ No
If yes, please list each allergy and the type of allergic reaction:

Medications:
Please list all medications (prescription and non-prescription) and supplements that you are currently taking. Please include dosage and frequency.

Family Health History:
Have any close family relatives (mother, father, brother, sister) had any of the following (if checked, please specify which relative): ❒ Unknown Family History

❒ Cancer _____
❒ Obesity _____
❒ High Blood Pressure _____
❒ Heart Trouble _____
❒ Stroke _____
❒ Asthma _____
❒ Allergies _____
❒ Diabetes _____
❒ Ulcers _____
❒ Stomach or Bowel Problems _____
❒ Gout _____
❒ Kidney Disease _____
❒ Kidney Disease _____
❒ Other _____

❒ Nerve/Muscle Disease _____
❒ Seizures _____
❒ Anemia _____
❒ Bleeding Problems _____
❒ Rheumatic Fever _____
❒ Alcoholism _____
❒ Mental Illness _____
❒ Physical Deformity _____
❒ Blind/Deaf _____
❒ Mental Retardation _____
❒ Hereditary Problem _____
❒ Death by Accident _____
❒ Death by Accident _____

Social History:
What is your marital status? ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated
Do you have children? ❒ Yes ❒ No
If yes, what are their ages? _____
Do you have any religious or cultural affiliation that may affect your medical care? ❒Yes ❒No
If yes, please describe: _____
In your opinion, have you experienced physical, sexual, verbal, or mental/emotional abuse?
❒ Yes ❒ No
If yes, please comment (optional): _____

Vocational History:
What is your work status? (Check one)
❒ Full-time ❒ Part-time ❒ Unemployed ❒ Retired ❒ Homemaker ❒ Off Work due to Injury
What is your occupation? _____
Do you have any work restrictions? ❒ Yes ❒ No
If yes, please describe: _____

Personal Habits:
Did/do you smoke? ❒ Yes ❒ No
Do you use medical Marijuana? ❒ Yes ❒ No
Did/do you drink alcohol? ❒ Yes ❒ No
If yes, how much per day? _____
When did you quit drinking? _____
Do you drink alcohol to control pain? ❒ Yes ❒ No
How many cups of caffeinated beverages do you drink per day? _____
What type of recreational drugs do you currently use or have used in the past (Marijuana, etc.)? _____

Function Index:
Do you require help lifting (i.e., 30-40 lbs., heavy suitcases, or a 3-4 year old child)?
❒ Yes ❒ No
Is your sitting generally limited to less than one-half hour? ❒ Yes ❒ No
Is traveling in a vehicle generally limited to less than one-half hour? ❒ Yes ❒ No
Is standing in one place generally limited to less than one-half hour? ❒ Yes ❒ No
Is your walking generally limited to less than one-half hour? ❒ Yes ❒ No
Do you regularly curtail or miss social activities because of your pain? ❒ Yes ❒ No
Are you able to do all of your activities of daily living yourself (bathing, dressing, etc.) ?
❒ Yes ❒ No
Please list activities you cannot perform: _____
Do you participate in any housework (laundry, cooking, cleaning, etc.) ? ❒ Yes ❒ No
If so, which chores? _____

Previous Injury History:
Please list any previous injuries you have had (motor vehicle accidents, bad falls, sports related accidents, etc.), how the injury occurred, and when it occurred.
1. _____
2. _____
3. _____
4. _____
5. _____

REVIEW OF SYSTEMS
OMT - Derek Rosol, DO

Patient Name: _____ DOB: _____

Are you **currently** experiencing any of the following symptoms? If yes, please check box(es)

General:
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Change
☐ Diet Change
☐ Fatigue

Eyes:
☐ Change in Vision
☐ Blurry Vision
☐ Double Vision
☐ Eye Pain
☐ Sensitivity to Light

Ears:
☐ Pain
☐ Discharge
☐ Decreased Hearing
☐ Ringing

Nose:
☐ Bleeding
☐ Discharge
☐ Sinus Pain

Mouth & Throat:
☐ Sores
☐ Tooth Pain
☐ Grinding
☐ TMJ Pain

Cardiovascular:
☐ High Blood Pressure
☐ Chest Pain
☐ Arm/Leg Swelling
☐ Palpitations

Respiratory:
☐ Chest Pain
☐ Cough
☐ Wheezing
☐ Snoring
☐ Shortness of Breath
☐ Daytime Sleepiness

Gastrointestinal:
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Fecal Incontinence

Genitourinary:
☐ Bladder Changes
☐ Discharge
☐ Pelvic Pain
☐ Incontinence

Musculoskeletal:
☐ Bone/Joint Pain
☐ Joint Swelling
☐ Stiffness
☐ Cramps
☐ Weakness

Skin:
☐ Rashes
☐ Skin Changes
☐ Suspicious Lesions
☐ Dryness
☐ Itching
☐ Birthmark(s) on Spine

Neurological:
☐ Paralysis
☐ Headaches
☐ Weakness
☐ Fainting
☐ Numbness
☐ Tingling
☐ Transient Loss of Speech
☐ Transient Loss of Vision
☐ Memory Loss
☐ Vertigo/Dizziness
☐ Spasticity
☐Tremors

Psychiatric:
☐ Anxiety
☐ Depression
☐ Confusion
☐ Irritability
☐ Memory Loss

Endocrine:
☐ Cold/Heat Intolerance
☐ Tiredness
☐ Weight Change
☐ Increased Thirst/Hunger
☐ Increased Urination

Hematologic:
☐ Abnormal Bruising
☐ Swollen/Tender Glands
☐ Bleeding

Allergy:
☐ Hives
☐ Rash
☐ Medication Allergies
☐ Seasonal Allergies
☐ Environmental Allergies

Patient Signature: _____ Date: _____