Osteopathic PDX
Mindful. Medical. Care.

PATIENT NAME AND DATE	
What is the reason for today's visit?	
When did your symptoms begin most recently?	
When did these symptoms begin originally?	
How long do your symptoms last?	Is it constant or intermittent?
What are you unable to do now that you could do before this problem began?	
Describe in your own words the details of any injury leading to the problem (date, what happened)	

Have you had any of these diagnostic studies for your current problem?

X-ray	❑yes ❑no	MRI (magnetic resonance imaging)	❑yes ❑no
CT (computed tomography) scan	❑yes ❑no	EMG/Nerve Conduction Study	❑yes ❑no
Nerve Conduction Study (NCS)	❑yes ❑no	Lab Work	❑yes ❑no

What increases your symptoms?

What decreases your symptoms?

Who may we thank for referring you?

Please list the providers that you have seen for this condition below.

Healthcare Provider	Dates	Healthcare Provider	Dates
1,_____	_____	3._____	_____
2._____	_____	4._____	_____

Have you had surgery for this or any other condition? If so, please list them below:

4039 N. Mississippi Ave. #203 ≋ Portland, OR 97227
Scheduling: 503.412.2392 ~ Office: 503.970.2303 ~ Fax: 503.719.7591
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MEDICATIONS AND DRUG ALLERGIES

SOCIAL HISTORY

Relationship status: ❑married ❑single ❑divorced ❑separated ❑partnered

Who lives with you, if anyone?

What type of work do you do and do you like it?

What do you do for physical activity?

Are you having fun on a regular basis?

Do you eat healthy food?

Where do you find fulfillment?

How satisfying is your home and family life?

How stressful is your life?

How do you unwind?

Do you consume any of the following?

❑Tobacco ❑Alcohol ❑IV Drugs ❑Recreational Drugs

TRAUMA HISTORY

Motor Vehicle Accident(s)? ❑yes ❑no How old were you?
Did you have symptoms that persist?

Concussions/Loss of Consciousness? ❑yes ❑no How old were you?

Have you suffered from abuse?
physically ❑yes ❑no emotionally ❑yes ❑no sexually ❑yes ❑no Age at time of abuse

Are you currently living in an abusive situation? ❑yes ❑no

Do you have any other significant prior injuries or trauma?

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RECENT REVIEW OF SYMPTOMS

General ❑difficulties sleeping ❑fevers or chills	**Circulatory** ❑blood clot(s) ❑abnormal bleeding ❑swelling in the arms or legs ❑leg cramps with walking	**Head** ❑headache ❑jaw clicking/popping ❑ear or jaw pain ❑sinus congestion ❑pain with bright lights ❑pain with loud noises	**Gastrointestinal** ❑nausea ❑vomiting ❑blood in stools ❑black stools ❑loss of control of bowels	**Neurological** ❑difficulty walking ❑numbness ❑dizziness ❑radiating pain ❑numbness in the inner groin
Eyes ❑double vision ❑eye pain ❑dry eyes **Skin** ❑rashes ❑skin changes	**Respiratory** ❑shortness of breath ❑pain with deep breathing	**Musculoskeletal** ❑muscle aches ❑joint stiffness ❑swollen/red joints ❑dropping things ❑morning stiffness ❑loose joints ❑weakness	**Endocrine** ❑weight change ❑appetite change ❑cold intolerance ❑heat intolerance ❑brittle hair ❑night sweats	**Genitourinary** ❑loss of control of bladder ❑pain with sexual intercourse

MEDICAL HISTORY

	Self	Family		Self	Family		Self	Family
Raynaud's Disease	❑	❑	PTSD	❑	❑	Thyroid Disease	❑	❑
Rheumatoid Arthritis	❑	❑	Suicide Attempt	❑	❑	Diabetes Mellitus	❑	❑
Gout	❑	❑	Chemical Dependency	❑	❑	Liver Disease	❑	❑
Ulcerative Colitis	❑	❑	Alcoholism	❑	❑	Kidney Disease	❑	❑
Crohn's Disease	❑	❑	Anxiety/Panic	❑	❑	Cancer	❑	❑
Psoriasis	❑	❑	Depression	❑	❑	HIV/AIDS	❑	❑
SLE/Lupus	❑	❑	Joint Replacement	❑	❑	Cardiac Disease	❑	❑
Ankylosing Spondylitis	❑	❑	Osteoporosis	❑	❑	Thoracic Outlet	❑	❑
Sleep Apnea	❑	❑	Osteoarthritis	❑	❑	Bleeding Disorders	❑	❑
Insomnia	❑	❑	Headaches	❑	❑	Carpal Tunnel	❑	❑
Fibromyalgia	❑	❑	Sinusitis/Rhinitis	❑	❑	Radiculopathy	❑	❑
Irritable Bowel	❑	❑	Scoliosis	❑	❑	Brain Injury	❑	❑

Is there any significant personal or family medical history not addressed above?

Thank you

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