Patient History

Health Center at Touro University Nevada
Neuromusculoskeletal Medicine/
Osteopathic Manipulative Medicine
874 American Pacific Drive
Henderson, NV 89014
Phone: (702) 777-4809

Patient: _____
First name Middle initial Last name

_____ _____ ☐ Female ☐ Male _____
Age Date of birth Date form completed

_____
Who referred you to our clinic? (doctor, family member, friend, other)

_____
If you were referred by a doctor, please include address above

_____
Who is your family doctor?

_____
Please include address above

Our Mission

This practice is limited to osteopathic neuromusculoskeletal/manipulative medicine, a medical specialty that focuses on the conservative restoration of neuromusculoskeletal balance. This is accomplished through the application of neuromusculoskeletal treatments, a "hands-on" approach that balances the tension within the body's tissues. The goal is for optimum balance in mechanical, neural, and circulatory movement.

This practice differs from other rehabilitative approaches since treatments are performed by physicians certified in the field of osteopathic neuromusculoskeletal/osteopathic manipulative medicine. Therefore, every attempt will be made to find a conservative approach to your neuromusculoskeletal problem. Post-treatment soreness is a common effect with treatment and this is part of the healing process. Specific stretches are also applied when your body is ready for these movements. Other influences toward optimum health will also be discussed with you including lifestyle decisions, nutritional considerations, and ergonomics to name a few. The aim is to correct the underlying cause for the problem you are experiencing.

Limitations to the successful application of neuromusculoskeletal treatment include the degree of degeneration, nutritional status, lifestyle decisions, follow-up on suggested activities, or the ability to continue with suggested treatments. In some cases, we will suggest a more formal plan of physical therapy, further diagnostic testing, or even further consultations for more invasive pain management. This can only be determined on an individual basis.

We request that if you are being referred by a physician that we receive all pertinent diagnostic testing that has been performed for your current problem. Additionally, we require a statement from your doctor delineating what they are requesting that we address with osteopathic neuromusculoskeletal treatment. Without this, we may have limited success in achieving the goal your physician has set for you.

Thank you for allowing us to serve you and for the time in completing this information.

Chief complaint: (One sentence key statement about your reason for this visit. Following this, you will be asked to describe the characteristics of this problem below.)

_____

_____

_____

Chronology of this problem: (When did this problem first begin? Was this the result of an accident or other injury? What examination and testing was done initially? What treatment was ordered? Please list the sequence of events from the beginning to the present time. Attach any further explanations that will help in your care.)

_____

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Location of the problem: (Where is the pain or limited movement located? Head, neck, shoulder, arm, chest, upper back, lower back, rib cage, legs, etc.? Does it go anywhere else?)

_____

_____

_____

_____

Quality of the problem: (What does the pain or limited movement feel like? Is the pain sharp, dull, burning, numbing, tingling, etc.?)

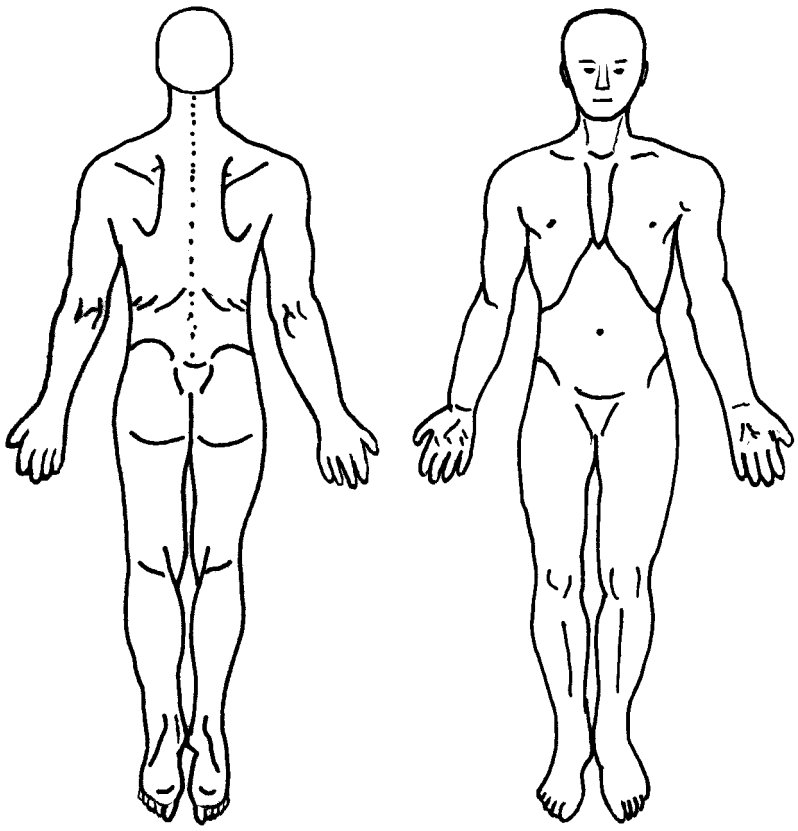
_____

_____

_____

Pain Diagram: Mark the areas on your body where you now feel pain using the following codes

Ache >>>>
Numbness ------
Pins & Needles 0000
Burning XXXX
Stabbing ////



What time of the day is best or worst for your pain?	Best (√)	Worst (√)	No Pain (√)
First awaking			
Morning			
Mid-day			
Afternoon			
Evening			
Nighttime			

How many hours a day are you in pain?	#

How severe is your pain?	(√)
None, I don't have pain	
Mild nuisance pain	
Mild to moderate but I can live with it	
Moderate, I am having difficulty dealing with it	
Severe, it is ruining my quality of life	

What activities increase or decrease your pain?	Increases Pain (√)	Decreases Pain (√)	No Pain (√)
Standing			
Sitting			
Lying			
Walking			
Running			
Kneeling			
Bending			
Lifting			
Pulling			
Pushing			
Reaching			
Climbing Stairs			
Getting up from chair			
Coughing or sneezing			
Sitting on long trips			

Diagnostic Tests: (List, in **order of occurrence**, any diagnostic test conducted to evaluate the problem you are currently presenting. Include x-rays, MRI, CT scan, bone scan, EMG, lab test, sleep study, or other tests performed.)

Test	Date Performed	Known Results

Chronology of Previous and On-going Treatments for this Problem

Treatment	Helped	No Difference	Worsened	When and for how long was this applied?	Is the treatment on-going?
Services					
Osteopathic Manipulation					
Chiropractic Manipulation					
Physical Therapy					
Pain Management					
Massage Therapy					
Surgery					
Acupuncture					
Psychiatric/Psychological					
Exercise					
Stretches					
Strengthening					
Aerobics					
Modalities					
Ultrasound					
Hot packs					
Ice					
Electrical stimulation (EGS)					
TENS unit					
Traction					
Gravity inversion					
Injections					
Steroid					
Trigger point					
Epidural					
Nerve block					
Facet joint					
Prolotherapy					
Oral Medications					
Anti-inflammatory					
Steroid					
Narcotic					
Anti-depressant					
Muscle relaxant					
Anti-anxiety					
Devices					
Heel lift					
Orthotic					
Back brace					
Other					
Meditation					
Biofeedback					
Reiki					

Medications:

Name of Medication (prescription & over-the-counter medications)	Strength	Doses per day	List the condition being treated with this medication.

Medication Allergies:

Name of Medication	Describe the allergic reaction you experienced.

Prior Trauma: (List, in **order of occurrence**, any major accidents, sports injuries, bad falls, or any other major traumas you have experienced? What treatment did you receive? Any lingering problems from this trauma?)

_____

_____

_____

Prior Surgical History: (List, in **order of occurrence**, any surgical procedures you have had. When did you have this surgery?)

_____

_____

_____

_____

Review of Body Systems: (Place a check (√) in box to the right if yes)

	√		√		√
General Constitution		Heart		Vascular/Connective Tissues	
Fatigue		High blood pressure		Anemia	
Fever or chills		Chest pain		Blood clots	
Night sweats		Heart attack		Easy bruising	
Nausea		Heart murmur		Swelling to hands or feet	
Unexpected weight change		Abnormal heart rhythm		Osteoarthritis	
Thyroid problems				Rheumatoid arthritis	
Diabetes		Lungs		Lupus	
Cholesterol problems		Difficulty breathing		Other connective tissue disease	
Skin		Chronic cough		Nervous System	
Hair loss		Asthma		Numbness to hands or feet	
Rashes		Emphysema		Coldness to hands or feet	
Skin lesions		Bronchitis		Dizziness	
Eyes		Pneumonia		Fainting episodes	
Eye glasses or contacts		TB		Seizures	
Blurred or altered vision				Headaches	
Disease of the eye		Kidneys/Bladder		Stroke	
Ears		Burning with urination		Questions for Women	
Difficulty hearing		Frequent urination		Breast lump/discharge/tenderness	
Ringing in ears		Frequent bladder infections		Painful intercourse	
Infections		Kidney stones		Menstrual irregularities	
Vertigo		Urinary incontinence		Number of pregnancies	#
Nose		Kidney disease		Number of live births	#
Change in smell or taste				Number of miscarriages	#
Chronic sinusitis/allergies		Gastrointestinal		Number of abortions	#
Nose bleeds		Stomach pain		Questions for Men	
Oral		Ulcer		Pain or swelling in testicles	
Difficulty swallowing		Reflux (GERD)		Prostate dysfunction	
Problems with teeth		Liver disease		Erectile dysfunction	
Dentures		Gall bladder disease		Painful intercourse	
Jaw pain		Diarrhea/loose stools		Abuse/Dependency Issues	
Cancer or tumors		Constipation		Alcoholism	
		Diverticulitis		Drug abuse	
		Hernia		Illicit substance use/abuse	
		Irritable Bowel		Subjected to physical abuse	
				Subjected to verbal abuse	

Family History: (Place a check (√) in box to the right if yes)

Condition	Self	Father	Mother	Brothers				Sisters			
				#1	#2	#3	#4	#1	#2	#3	#4
Healthy											
Deceased (age)											
Alcoholism											
Allergies											
Anemia											
Asthma											
Arthritis											
Cancer (if yes list below)											
Diabetes											
Depression											
Elevated cholesterol											
Heart attack											
Hypertension											
Mental illness											
Muscle disease											
Nerve disease											
Obesity											
Stomach disorder											
Stroke											
Thyroid Problems											

Social and Work History:

Occupation _____ Are you retired? Yes ☐ No ☐

Are you currently working? Yes ☐ No ☐ If no, when was the last day worked? _____
Are you missing work due to this problem? Yes ☐ No ☐
Are you disabled? Yes ☐ No ☐ If yes, what is your disability? _____
Is your current problem related to a workman's compensation case? Yes ☐ No ☐
Is your current problem related to a motor vehicle case? Yes ☐ No ☐
What is your marital status? Single ☐ Married ☐ Divorced ☐ Widowed ☐
Do you have children? Yes ☐ No ☐ If yes, what are their ages? _____
Do you currently smoke or chew tobacco? Yes ☐ No ☐ If yes, complete below

Tobacco	Quantity (#, packs, ounces)	daily √	weekly √	monthly √	Rarely √	Number of Years
Cigarettes						
Cigars						
Chewing						
Other						

Do you consume wine, beer, or other alcoholic beverages? Yes ☐ No ☐ If yes, complete below

Beverage	Amount(#)	daily √	weekly √	monthly √	Rarely √
Beer (glasses)					
Wine (glasses)					
Liquor (ounces)					
Other					

Do you consume caffeinated beverages? Yes ☐ No ☐ If yes, complete below

Beverage	Amount (# of 8 ounce servings)	daily √	weekly √	monthly √	Rarely √
Coffee					
Tea					
Soda pop					
Other					

Do you perform regular exercise? Yes ☐ No ☐ If yes, complete below

_____

_____

_____

How many hours of sleep do you get per day? _____
Is your sleep regularly disturbed due to pain? Yes ☐ No ☐
Do you feel rested in the morning? Yes ☐ No ☐