

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

Age Date of birth Female Male 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.

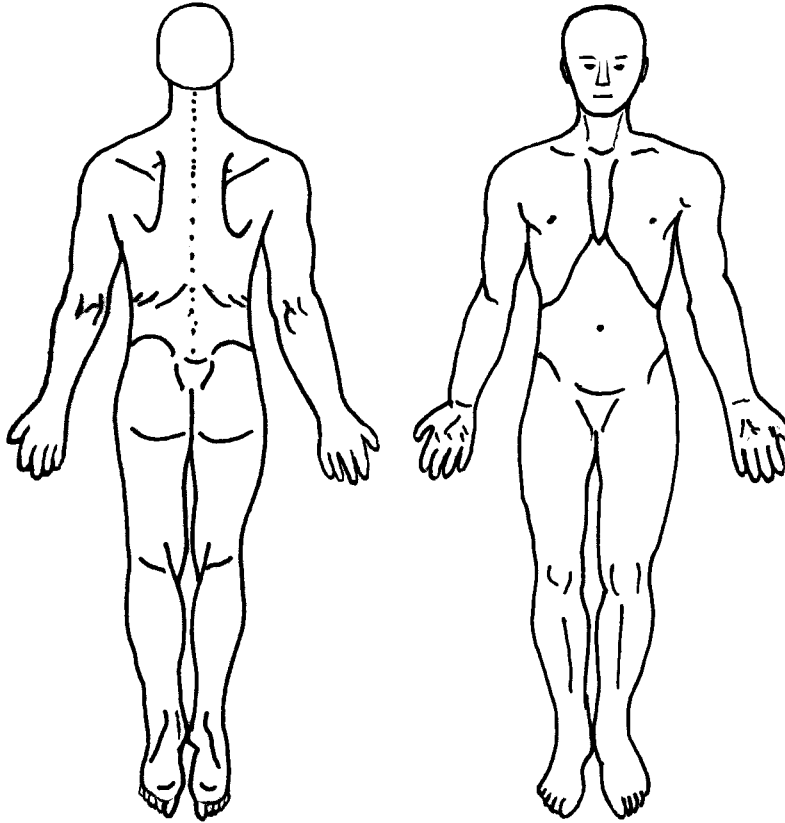
Limitations to the successful application of neuromusculoskeletal treatment include the degree of degeneration, nutritional status, lifestyle decisions, follow-up on suggested activities, or the ability to continue with suggested treatments. In some cases, we will suggest a more formal plan of physical 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.

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 (√)	What activities increase or decrease your pain?	Increases Pain (√)	Decreases Pain (√)	No Pain (√)
First awaking				Standing			
Morning				Sitting			
Mid-day				Lying			
Afternoon				Walking			
Evening				Running			
Nighttime				Kneeling			
How many hours a day are you in pain? #				Bending			
How severe is your pain?				Lifting			
			(√)	Pulling			
None, I don't have pain				Pushing			
Mild nuisance pain				Reaching			
Mild to moderate but I can live with it				Climbing Stairs			
Moderate, I am having difficulty dealing with it				Getting up from chair			
Severe, it is ruining my quality of life				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 <input type="checkbox"/>	weekly <input type="checkbox"/>	monthly <input type="checkbox"/>	Rarely <input type="checkbox"/>	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 <input type="checkbox"/>	weekly <input type="checkbox"/>	monthly <input type="checkbox"/>	Rarely <input type="checkbox"/>
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 <input type="checkbox"/>	weekly <input type="checkbox"/>	monthly <input type="checkbox"/>	Rarely <input type="checkbox"/>
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