



Osteopathic manipulative treatment (OMT) New Patient Form

Please fill out this form to the best of your ability

Patient Name _____ Date _____

What is your Height _____ Weight _____ Hand donunce (circle one): Right / Left / Ambidextrous

What is your chief complaint? _____

How do you believe your health concern/pain began? _____

When did you notice this health concern/pain? _____

What positions or activities aggravate your condition? (Choose all that apply):

- Coughing
- Sneezing
- Standing
- Movement
- Lifting
- Sitting
- Bowel movement
- Laying down
- Driving
- Going up/down stairs
- Other

Describe other: _____

What positions or activities relieve your condition? (Choose all that apply):

- Rest
- Standing
- Movement
- Walking
- Hot or cold application
- Sitting
- Laying down
- Self massage
- Massage Therapy
- Hot shower or bath
- Medication (over the counter or prescription)
- Exercise
- Other

Describe other: _____

Please rate the severity of your complaint as it pertains to your life:

- Mild - annoyance, no impairment of my life
- Slight - some mild impairment of my life
- Moderate - marked impairment of my life
- Severe - incapacitating/bed ridden - I can't go to work

Please rate the pain on a 0-10 scale:
"0" being no pain/tightness/severity and "10" being the worst pain/tightness/ severity imaginable _____

How often are you experiencing your complaint?:

- Occasionally - approximately 25% of your awake hours
- Intermittently - approximately 50% of your awake hours
- Frequently - approximately 75% of your awake hours
- Constantly - approximately 100% of your awake hours
- Other - please describe

What activity or hobby have you not been able to perform because of your pain? _____

Have you ever had this, or a similar condition before? Yes / No

If yes, when and what did you do to relieve the problem?

Personal Health History

Name of your Primary Care Physician: _____
Address: _____

Phone number: _____

Please list and approximate dates of past hospitalizations;surgeries/fractures NONE

Have you had **any** of the following and approximate month/year:
Blood test: Yes No _____ X-rays: Yes No _____ MRI: Yes. No _____ CT: Yes / NO _____

If yes, what body part imaged (i.e. neck head. back etc.) and general results/diagnosis given:

Name of Doctor ordering tests:

Do you have or have you had any other significant health conditions (ie: High Blood Pressure. Diabetes. Cancer. AIDS. etc.)
If **yes** please list (include approximate year of diagnosis): NONE

Please list medications (including over the counter) NONE

Please list Vitamins/Supplements taken on a regular basis: NONE

Do you have any **allergies, sensitivities** Yes / No Please list:

Use of Alcohol: Never / Rarely. Social / Light / Moderate : Daily amount: _____
Use of Tobacco: Never / Rarely / Previously, But Quit / Currently Packs A Day _____
Recreational drugs: Sever / Rarely / Daily / Previously, But Quit type _____
Exercise per week: 0-1 2-3 4-5 6-7 Activities: _____
Do you **wear** arch supports? YES NO
Have you had chiropractic health care before? YES NO Doctor: _____
When _____

Family Medical History

Age Diseases If Deceased. Cause Of Death
Father: _____
Mother: _____
Siblings: - _____
Other: _____

Please answer the following. Do you have, or had a change in:

- | | |
|---|---|
| Sore that does not heal Yes / No | Difficulty swallowing Yes / No |
| Sagging hoarseness Yes / No | Vertigo (dizziness) Yes / No |
| Headaches for hours or days Yes / NO | Blurred vision Yes / No |
| Sight sweats Yes / No | Numbness or sensation problems Yes / No |
| Double vision Yes / No | Slurred speech Yes / No |
| Nausea or vomiting Yes / No | ringing in the ears Yes / No |
| Loss of consciousness Yes / No | Have a history of stroke in your family Yes / No |
| Does your pain ever make you from a sound sleep? Yes No | Have you had loss of bladder or bowel control? Yes / No |
| Are you losing weight without trying? Yes / No | Weakness or strength loss? Yes / No |
| Are you coughing up blood or noticing it in your stools? Yes / No | Sudden collapse without loss of consciousness? Yes / No |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Chiropractic is natural, and therefore, one cannot always expect immediate results. Chiropractic is known for the "adjustments" given to the spine. It has been proven very safe, even for children!

New Zealand Report- 2 year study identifying that adjustments are safe when carried out by chiropractors ONLY. Training consisting of almost 8 years allows the chiropractor to know if the adjustment is contraindicated.

Magna Report- Ontario Ministry of Health indicated through research that chiropractic is exceptionally safe for low back pain over standard medical treatments.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if occurs you should report it to your doctor.

Stroke - Stroke is the most serious complication of chiropractic treatment. Studies estimate (Journal of the C.A.A., Vol. 37 No. 2, June, 1993) that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. The Protective Agency put out a Canadian study recently that indicates risk is only 1 in every 6 million adjustments.

If you have any questions concerning this form or the above statements, please ask your doctor.

I hereby give my informed consent to have chiropractic treatment administered.

Name of Patient _____

Date _____

Signature of Patient (parent or guardian if minor) _____

Print Name _____

Doctor's Comments _____

Doctor's Signature _____