CHRISTOPHER BROWN D.O. - TRADITIONAL OSTEOPATHY

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REGISTRATION PAGE

Date: _____

Name: _____

DOB: _____ Age: _____

Sex: _____

Address: _____

_____

Phone Number: _____ (cell) _____ (other)

Email: _____

Occupation: _____

Number in Household: _____ Marital Status: _____

Number of Children (with ages) : _____

Emergency Contact (name and phone number): _____

_____

Referred By: _____

Office Policies:

- 48-hours (2 business days) cancellation notice
- For “no-shows” and late cancellations, you are charged half of treatment fee
- We do not bill insurance directly
- We do not take Medicare/Medical nor Workman’s Comp
- Payment is required at the time of your visit. We accept cash, check or credit

I have read and agree to honor all office policies.

SIgned _____ Date _____

MEDICAL INTAKE FORM

Name: _____ Date: _____

Please describe the reason for your visit today along with relevant information such as dates and significant events.

_____

_____

_____

_____

Please list all medical issues that you have been diagnosed with in the past or are currently dealing with.

_____

_____

_____

Please list all medications you are currently taking along with dosages.

_____

_____

List all allergies you have to drugs or the environment.

_____

_____

Please list your primary care physician along with any other physician who is involved in your care.

_____

_____

Please list all therapies and treatments that you have tried or are using currently.

_____

_____

Please list any major accidents, injuries or traumas you have had along with year they occurred.

_____

_____

Please list any surgeries you have had and when you had them.

_____ _____

_____ _____

_____ _____

Please describe your health goals.

_____

_____

Family History: (If there is a positive history, please write which relative applies in the line. If there is no history, leave blank)

Tuberculosis	_____	Mental Illness	_____
Diabetes	_____	Leukemia	_____
Heart Disease	_____	Migraines	_____
Hypertension	_____	Thyroid Disease	_____
Stroke	_____	Osteoporosis	_____
Epilepsy	_____	Hepatitis	_____
Asthma	_____	Cancer	_____
Anemia	_____		_____
Bleeds Easily	_____		_____
Substance Abuse	_____		_____

Please put a check by any of these conditions that you have or have had.

❒ Decreased hearing
❒ Ringing in ear
❒ Ear infections
❒ Dizzy or fainting spells
❒ Failing vision or eye pain
❒ Double or blurred vision
❒ Nose bleeds – recurrent
❒ Sinus trouble
❒ Sore throats – frequent
❒ Hoarseness – prolonged
❒ Hayfever /Allergies
❒ Pneumonia / Pleurisy
❒ Bronchitis / Chronic cough
❒ Asthma / Wheezing
❒ Shortness of breath
❒on exertion ❒lying flat
❒ Chest pain
❒ High blood pressure
❒ Heart murmur
❒swollen ankles
❒irregular pulse
❒palpitations
❒ Leg pain when walking
❒ Varicose veins / Phelebitis
❒ Cold numb feet
❒ Loss of appetite - recent
❒ Difficulty swallowing
❒Heartburn
❒ Peptic ulcare
❒ Persistent Nausea / Vomiting
❒ Abdominal Pain - chronic
❒ Gallbladder trouble
❒ Jaundice / Hepatitis
❒Diarrhea
❒ Constipation
❒Diverticulosis
❒ Chron's / Colitis
❒ Inflammatory Bowel Syndrome
❒Bloody or tarry stool
❒ Hemorrhoids
❒ Hernia

❒ Urination / Overactive bladder
❒ Overnight more than twice
❒ More than 8 times / 24 hrs
❒ Urgency to urinate
❒with leakage
❒ Decrease in force/flow
❒ painful
❒ Stress incontinence – urine leakage with exercise
❒Blood in urine
❒ Kidney stones
❒ Urine infections – frequent
❒ Sexually transmitted diseases
❒ Sexual problems
❒ Weight loss ❒Gain – recent
❒ Anemia ❒Bruise easily
❒ Blood transfusions
❒ Cancer ❒Chronic fatigue
❒ Diabetes ❒Thyroid disease
❒ Seizures ❒Stroke
❒ Tremor / hands shaking
❒ Numbness / tingling
❒ Headaches – frequent
❒ Arthritis / Rheumatism
❒ Back pain – recurrent
❒ Bone fracture / joint injury
❒ Osteoporosis
❒ Foot pain ❒Gout
❒ Rashes ❒Hives
❒ Psoriasis ❒Eczema
❒ Any type of sleeping difficulty
❒ Depression ❒Nervousness
❒ Agitation ❒Memory loss
❒ Moodiness ❒ Suicidal thoughts
❒ Phobias ❒Mental illness
❒ Feelings of worthlessness
❒Rheumatic fever ❒Scarlet fever
❒Chickenpox ❒Polio

❒Measles ❒German measles
❒ Mumps
❒ Tuberculosis ❒Herpes
❒ AIDS / HIV
❒ Alcohol ____ oz/week
❒ Coffee / Tea ____cups per day
❒ Smoking _____cig/day
years ____ year quit____
❒ Exercise
_____
❒ Street drugs
_____
❒ Acupuncture / tattoos
❒Hair loss _ progressive _ recent

MALES: ❒ Prostate problems

FEMALES *Please complete:*
Menstrual Flow:
❒Regular ❒ Irregular ❒ Pain/ Cramps
Days of flow _____ Length of cycle ____
Date of 1st day of last period
_____
❒Pain / Bleeding during or after sex
Number of Pregnancies _____
Abortions _____
Miscarriages _____
Live Births _____
Birth control method
_____
❒ Flushing / Menopause
Date of last PAP test
_____
❒Normal ❒Abnormal
Date of last mammogram
_____
❒Normal ❒Abnormal