Katherine A. Worden, DO, FAAO

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**New Patient Form-Adolescent**

(I want **YOU** to fill this in. Feel free to ask your parent if you need help)

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Parent Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Major Cross Sts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family/Pediatric Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring: Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Non-Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Note – Important Information**

Prior to your first visit:

* Please have any relevant imaging reports and/or office notes sent to our office.
* Be aware, we do not bill insurance directly at our office.
* **Be Aware: This is a residential area** 
  + **You will need the Gate Code: #0713**
  + **Please** 
    - **Park in the driveway.**
    - **Please come in -you do not need to ring the bell.**

**Reason(s) for visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications/OTC/Supplements:** (please include dosage and how taken per day or prn [as needed]) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Problems:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries/Procedures (age or date):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** circle (or mark x as needed)

Father: living/deceased Age: \_\_\_\_\_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: living/deceased Age: \_\_\_\_\_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of sisters: \_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of brothers: \_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle (or mark x) if present in any blood relatives (including parents, grandparents, brothers, sisters, children, cousins, aunts, or uncles):

Diabetes Cancer(type)\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure Autoimmune Disease

Heart Disease Lung Disease Tuberculosis Stroke

Epilepsy Psychiatric Illness Migraine Headaches Thyroid Disease

Arthritis Suicide Kidney Disease Liver Disease

Glaucoma Alcohol or Drug Dependency Blood Disease Joint Hypermobility

Co-Vid Infection: yes/no severe: yes/no died: yes/no

Other inherited conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

**Nutrition:** Any dietary restrictions/food sensitivities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had difficulty losing (Yes No) or gaining weight (Yes No)?

**Activities:** Interests/Sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have trouble sleeping? Yes No. How do you de-stress?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identity:** Please mark how you consider your gender/sexuality:

Male/He/Him Female/She/Her They/them Other\_\_\_\_\_\_\_\_\_\_\_\_

Heterosexual bisexual queer lesbian nonbinary trans celibate Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Support:** Who is your main emotional support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pets? Yes No Is so, what type and names? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faith background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel safe at home? Yes No If not, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits:**

*Caffeine:* coffee/soda/diet soda/tea/energy drink? Yes No. How many servings/day? \_\_\_\_\_\_\_\_\_\_

*Tobacco:* Do you smoke/chew/vape/e-cigarette? Yes No.

*Alcohol:* Do you drink? Yes No. If yes, how many drinks/week? \_\_\_\_\_ of what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Substances:* Recreational drug use? Yes No. If yes, what type and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you have a problem with usage? Yes No. Interested in help regarding your usage? Yes No

Image

\_\_\_\_\_\_\_\_ Which number (0-10) describes your pain right now?

\_\_\_\_\_\_\_\_ Which number (0-10) describes your pain at its worst?

\_\_\_\_\_\_\_\_ Which number (0-10) describes your pain at its least?

**Osteopathic History:**

**Birth History**: (please circle or mark with X)

Mother’s problems or illness when pregnant with you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery: Vaginal C-section Premature\_\_\_weeks On-time Post dates\_\_Birth Wt:\_\_\_\_\_\_\_\_\_\_

Feeding: Breast Bottle Problems: Feeding Colic Flat spot on head Head only turns one way Constipation Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood History:**

Generally healthy Lots of ear infections Tongue/lip tied Headaches Depression Anxiety Behavior

Trouble with school/reading? yes no. Problems with bullying? yes no. Thoughts of suicide? yes no.

Illnesses/Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental: braces teeth pulled palate expander \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Life Stressors: family death divorce Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

(Please circle/x any symptoms/conditions you have experienced)

**General:** **Head, Eyes, Ears, Nose** **Musculoskeletal:**

Fevers **and Throat:** Joint pain/red/warmth/swelling

Problems with sleep Eye problems Neck, Back, Arm, Leg pain

Concerns about weight gain Difficulty swallowing Headache

Hearing problems Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular:** Ear Infections as a kid

Chest pain Recurrent sore throat **Skin:**

Heart problems Allergies/Sinus problems Rashes

Murmur Acne

**Gastrointestinal:** Itching

**Respiratory:** Reflux **Neuro/Psych:**

Cough or wheezing Abdominal pain/spasm Tremor/shaking

Short of breath Diarrhea/Constipation Hyperactive

Asthma Blood in bowel movement Poor eye contact/Space out

Covid mild/severe Weakness in arm/leg

Exposure to Tuberculosis **Genitourinary:** Seizure disorder Bladder infections/UTIs Life Stress problems

**Breast**: Sexually active/ Birth control Recent family upsetting event

Pain or mass Sores or pain in genitals Trouble making friends

Discharge Discharges/Lumps/ Hernia Developmentally behind

Kidney problems Anxious/Depressed/Suicidal

**Blood:**

Bruise easily **Endocrine:**

Swollen glands Fatigue, excess thirst or urination

Anemia/Polycythemia Diabetes, thyroid problems

Growth or weight concerns

**Is there anything else you would like help with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any questions for me, about anything? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMED CONSENT FOR OSTEOPATHIC MANIPULATIVE MEDICINE:**

**I understand that Dr. Worden is a specialist in Osteopathic Manipulative Medicine (OMM) which includes hands-on medical treatment called Osteopathic Manipulative Treatment (OMT) for improved health and relief of pain and dysfunction. Research has shown these techniques to be safe and effective for many common conditions. The most common side effect is temporary aching or soreness from the technique releasing toxins that must be cleared by your body that may last for 1-3 days. This clearance is enhanced by drinking more water and resting your body. If it lasts more that 3 days or is severe, please contact Dr. Worden. Young adults may commonly sleep quite soundly the night following the treatment as the nervous system resets.**

**Rarely (1 per 3 million), OMT of the Cervical spine has been associated with severe neurologic injury or death. This has been found to occur in individuals who are predisposed to injury in this area and/or when hyperextension and hyper-rotation are applied during an outdated thrusting technique that is no longer taught in Osteopathic Medicine. Dr. Worden will screen you for such predisposition and avoids the outdated maneuver. Although it is very safe when done properly, if you would prefer, you may decline such a popping technique in the neck as many other techniques are available.**

**(Note the risk for a severe GI bleed from the use of an NSAID medication is 1-2 per 100)**

**I agree to the use of OMM as a part of my treatment with Dr. Worden.**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that Dr. Worden is also a valued professor of OMM. I agree to have occasional advanced medical students or residents present and participating in my treatment when appropriate per Dr. Worden.**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**