Kate's Corner Osteopathic Care PLC

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New Patient Form

Name: _____ Date: _____

Date of Birth: _____ Current Age: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Pharmacy:

Name: _____Major Cross Sts: _____ Phone: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Primary Care 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.**
    - **Come in -you do not need to ring the bell.**
    - **Use the wrist blood pressure cuff & mark your BP & pulse on a sticky pad with your name on it to give to Dr. Worden at your visit.**

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Reason(s) for visit: _____
_____

Allergies (reaction): _____

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Surgeries/Procedures (date):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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:

Identity:

Please circle (or mark x) one item that best describes your situation:

Married	Divorced	Living with significant other
Widowed	Single	Other _____

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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_____
How far did you go in school? Grade school High school College (2 yr/ 4yr) other _____

Support:
Do you have:
Children? Yes No If so, what are their names & ages? _____
Grandchildren? Yes No If so, how many & what are their ages? _____
Pets? Yes No Is so, what type and names? _____
Are you currently a caregiver? Yes No If so, who and why? _____
Who is your main emotional support? _____
Faith background: _____
Do you feel safe at home? Yes No If not, why not? _____

Activities:
Work: Retired? Yes No Semi. Occupation (former if retired): _____
Hazardous chemical/environmental exposures? _____
Interests/hobbies: _____
Exercise: (type & frequency): _____
_____
How do you de-stress? _____

Nutrition: Any dietary restrictions/food sensitivities? _____
Have you ever had difficulty losing (Yes No) or gaining weight (Yes No)? Do you want help? _____
Typical meals/snacks and mealtimes on an average day: _____
_____
_____
_____

Sleep: Do you sleep well? Yes No How many hours per night on average? _____
If you have trouble, do you have more trouble falling asleep or staying asleep or both? _____
How many times do you wake up at night? _____ What keeps you from sleeping? _____

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. Have you ever quit using before? Yes No.
Are you interested in help regarding your usage? Yes No

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Review of Systems

(Please circle/x any symptoms/conditions you have experienced in the past 12 months)

General:
Weight change
Concerns about weight
Problems with sleep
Fevers
Fatigue
Chills
Weakness
Tremors
Low sex drive
Bruise easily
Dizziness

Cardiovascular:
Chest pain or pressure
Irregular heartbeats
Murmur
Stroke/mini-stroke/TIA
Heart Attack/MI
Poor circulation
Swelling in legs/feet
High Blood Pressure
Fainting
High cholesterol

Respiratory:
Cough or wheezing
Short of breath
Exposure to Tuberculosis
Bronchitis/pneumonia
Covid mild/severe

Women:
Date of Last Period ____
Pregnancies___ Births___
Menstrual problems
Pain___ Poor Libido__
Date last Pap____
Concerns about menopause?
Sexually active? Yes No
If yes, with women men both
Birth control _____
Last bone density scan_____
Breast:
Lumps
Pain/tenderness
Discharge
Last mammogram_____
Any other Symptoms not listed? _____

Head, Eyes, Ears, Nose and Throat:
Eye problems
Date last eye exam _____
Date last dental exam _____
Dental problems
Seasonal allergies
Ringing in ears
Hearing problems
Earaches
Recurrent sore throat
Sinus problems
Sores in mouth
Nosebleeds
Thyroid problems
Difficulty swallowing
Head injury/Concussion

Gastrointestinal:
Nausea/vomiting
Indigestion
Acid reflux/heartburn
Diarrhea/Constipation
Colon polyps
Last colonoscopy _____
Blood in bowel movement
Abdominal pain/spasm
Loss of bowel control
Hepatitis/Pancreatitis

Genitourinary:
Change in urinary frequency
pain with urination
Sexual problems
Leaking/can't hold urine
Bladder infections
Kidney infections/stone
Kidney problems
Dialysis/ Transplant

Men:
Pain in genitals
Lumps/ Discharges
Hernia
Sexually active? Yes No
If yes, with women men both
Sexual concerns
Do you use condoms? Yes No

Musculoskeletal:
Joint pain/ swelling
Joint redness/warmth
Neck pain
Back Pain
Joint injury _____
Osteopenia/osteoporosis
Osteoarthritis
Shoulder pain
Elbow/wrist/hand pain
Buttock/leg pain
Knee/ankle/foot pain
Muscle spasms

Skin:
Hives
Rashes
Loss of hair
Ulcerations/sores
Itching
Changing moles
Acne
Non-healing sores

Neurologic:
Headache/migraine
Black out/pass out
Numbness
Tingling
Tremor/shaking
Weakness in arm/leg
Seizure disorder

Neuropsychiatric:
Stress problems
Anxious
Panic attacks
Depressed/ Suicidal
Recent upsetting event:
_____
Trouble remembering

Blood:
Anemia/Polycythemia
Swollen glands
Concern for HIV/AIDS

Endocrine:
fatigue, excess thirst, urination, diabetes, thyroid problem

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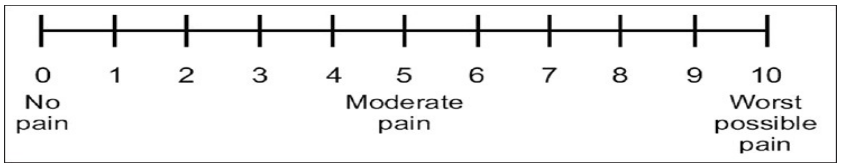
Osteopathic History:

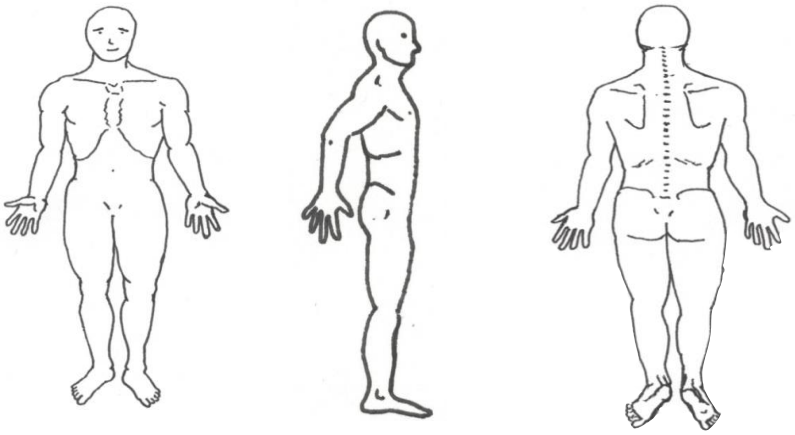
Birth History: (please circle or mark with X)
Mother's problems or illness when pregnant with you_____
Delivery: Vaginal C-section Premature___weeks On-time Post dates__Birth Wt:_____
Feeding: Breast Bottle Problems: Feeding Colic Flat spot on head Head only turns one way Constipation
Other: _____

Childhood History:
Generally healthy Lots of ear/throat infections Tongue/lip tied Headaches Depression Anxiety
Illnesses/Injuries: _____
Major Life Stressors: family death divorce Other_____

Adulthood History:
Generally healthy Major Life Stressors: family death divorce Other_____
Major Illnesses: _____
Trauma: Head Tailbone Car Accident Other_____
_____
_____
Do you have problems with pain or function of your: Head Neck Shoulders Elbows Wrists Hands Chest Abdomen Upper/Middle back, Low back, Pelvis Hips Knees Ankles Feet ? Please explain:
_____
_____
_____
Other Issues you want to discuss: _____
_____



_____ 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?



Please mark the Diagram with:
N = Numbness
P = Pins & Needles
A = Achy Pain
S = Sharp pain
B = Burning Pain

What has helped you in the past? Hot pack, Ice, Traction, Bedrest, Osteopathic OMT, Physical therapy, Chiropractic, Massage therapy, Brace, Prolotherapy, PRP, TENS unit, Pain shots, Pain pills, Other:_____
Which of these has made you feel worst?

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Please circle all of the following physicians or specialists you have consulted **for pain relief for the current problem.**

Acupuncturist	General Physician	Osteopathic Physician
Chiropractor	Hypnotist	Pain Clinic
Dentist	Neurologist	Physical Therapist
ENT Physician	Neurosurgeon	Podiatrist
Nutritionist	Orthopedic Surgeon	Psychiatrist
Psychologist	Rheumatologist	Other_____

INFORMED CONSENT: 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.
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.

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.

Signature_____ **Date**_____