Osteopathic Physicians of the Potomac

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex (M/F): _____ Preferred Name: _____

Primary Address: _____

Mailing Address (if different): _____

Primary Phone: (___)_____ Secondary Phone: (___)_____

Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: (___)_____

Primary Care Provider: _____ PCP Contact Number: (___)_____

Who referred you? _____ Referral Phone Number: (___)_____

Patient Financial Obligation Agreement: I understand that all payments are due at the time of service. I agree, to be financially responsible and make full payment for all charges. I understand that if I elect to make full payment at the time of encounter, that I will be given an opportunity to directly submit charge information to my insurance company. I understand that this is my personal responsibility and do not hold Osteopathic Physicians of the Potomac responsible for performing this action on my behalf nor do I hold them responsible for any charges that are not reimbursed by my insurance company.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the Osteopathic Physicians of the Potomac Notice of Privacy Practices (NOPP). ☐ Received ☐ N/A (only if you received the notice from us previously)

Authorization to transmit information

I authorize the staff of Osteopathic Physicians of the Potomac to transmit any required information either electronically or in paper form to my insurance entities for the purposes of receiving payment for services rendered on my behalf.

I read and agree to all of the above (Financial Agreement, Notice of Privacy Practices, Transmission Authorization)

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature:_____ Date: _____

Name: DOB:

General Medical Questionnaire

Please list any past medical problems you have had or continue to have (e.g. diabetes, hypertension, etc.). Please include any significant injuries you have had in the past.

_____
_____
_____
_____

Please give previous hospitalizations or surgeries with approximate dates:

Surgery/Hospitalization	Year	Complications

Provide any medical conditions present in any **first-degree** (parents, siblings, children) relatives:

_____
_____
_____

Social History

Do you smoke? _____ Ever smoked? _____ If yes, how many years? _____ Packs/day avg:_____

Do you drink alcohol? _____ If yes, drinks/week:_____ Any other drug use?_____

What is your current work situation? _____

Medication Allergies (if none, write "none") **Reaction (hives, rash, throat swelling, etc.)**

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications (include supplements)

Medication	Dose/ Freq	Medication	Dose/ Freq

Name: DOB:

Reason for visit:_____

How long has this been a problem? _____

If there is pain involved, please indicate on figure to the right

Describe the pain (ache, sharp, burning, etc.)

_____

Provide context of how this started: _____

What treatments have you tried? _____

What makes the problem better? _____

What makes the problem worse? _____

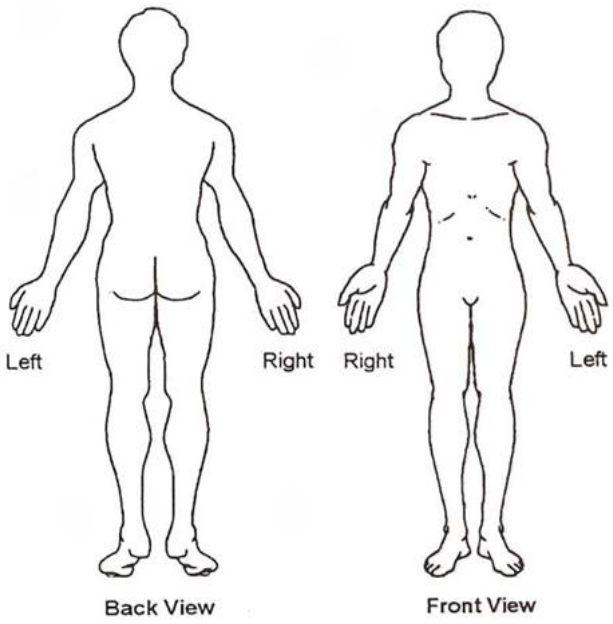
Additional Information: _____

_____

_____

_____

Please Mark on the figures below, the location of your discomfort, if applicable.



Review of Systems

Please indicate all of the following that you have experienced in the last **4 weeks**.

If you do not check a box, it will be assumed to be equal to a denial of the presence of the particular symptom

Constitutional

☐ Fever ☐ Fatigue ☐ Sleep Problems

☐ Chills/Sweats ☐ Weight changes (specify) _____ ☐ Other:

Head, Eyes, Ears, Nose, Throat

☐ Visual disturbances ☐ Runny nose ☐ Dizziness

☐ Decreased hearing ☐ Sinus pain/pressure ☐ Ringing in ears

☐ Itchy eyes ☐ Congestion ☐ Earache

☐ Eye pain ☐ Flu-like symptoms ☐ Other:

Cardiovascular

☐ Chest pain/pressure ☐ Leg pain when walking ☐ Leg swelling

☐ Palpitations ☐ Exercise intolerance ☐ Other:

Name: DOB:

Respiratory

☐ Shortness of breath ☐ Chest congestion ☐ Wheezing

☐ Cough ☐ Coughing sputum ☐ Other:

Gastrointestinal

☐ Abdominal pain ☐ Constipation ☐ Rectal pain

☐ Blood in stool ☐ Diarrhea ☐ Bowel incontinence

☐ Vomiting ☐ Black stools ☐ Other:

☐ Nausea ☐ Heartburn

Neurological

☐ Headache ☐ Poor coordination ☐ Fainting

☐ Dizziness ☐ Burning sensation ☐ Seizures

☐ Abnormal balance or gait ☐ Numbness/tingling ☐ Other:

Musculoskeletal

☐ Joint pain ☐ Back pain ☐ Muscle weakness

☐ Joint swelling ☐ Muscle cramps ☐ Other:

☐ Neck pain ☐ Muscle pain

Genitourinary

☐ Urinary frequency ☐ Pain with urination ☐ Testicular pain/swelling

☐ Incontinence ☐ Frequent nighttime urination ☐ Other:

☐ Urinary Urgency ☐ Erectile dysfunction

Integumentary

☐ Rash ☐ Wound/Laceration ☐ Skin Cancer

☐ Boil/abscess ☐ Skin infection ☐ Other:

Psychiatric

☐ Depression ☐ Anxiety ☐ Other:

Hematologic/Lymphatic

☐ Easy bruising ☐ Easy bleeding ☐ Other:

☐ Swollen Lymph nodes

Endocrine

☐ Excessive thirst ☐ Hot/cold intolerance ☐ Other:

Supplemental Questions

Have you ever had Osteopathic, Chiropractic, or other manipulative medicine? _____

Are there any special considerations you would like the physician to know? _____

List any specific health goals you have: _____

What barriers to health exist for you? _____

Do you engage in spiritual practices? _____

Note to patients: If you are interested, please know that we take spiritual care very seriously here and as such we would be happy to pray with you at your request.

PHYSICIAN USE ONLY: Physician Signature: _____ Date: _____