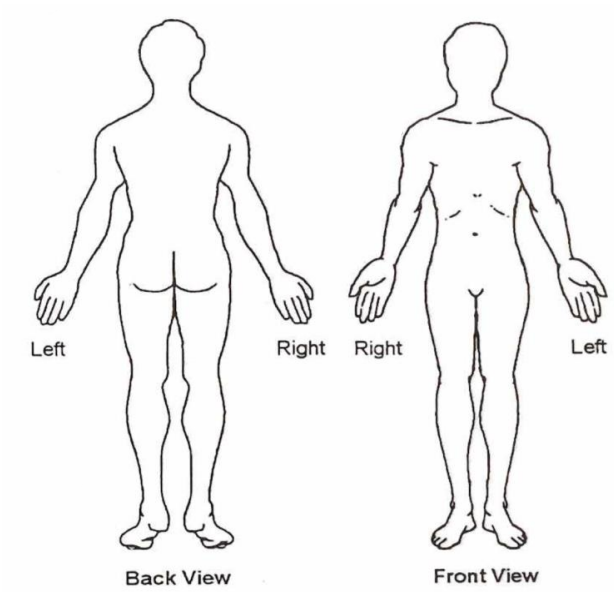
Osteopathic Physicians of the Potomac

Name: _____ Date:_____

Age: _____ ❑ Male ❑ Female

For nurse use:	BP:	HR:	RR:
	Ht:	Wt:	BMI

Please circle the location(s) of your problem on the diagram below.



Reason for visit? _____

_____

_____

When did your problem begin? _____

How often do you experience this problem?

❑ Constantly ❑ Occasionally ❑ Rarely

What caused your symptoms: ❑ Unknown ❑ injury

❑ Describe/Other:_____

Which best describes your problem?

❑ Improving ❑ Stable ❑ Worse ❑ Resolved ❑ Fluctuating

What makes your problem feel <u>WORSE</u>?

_____

What makes your problem feel <u>BETTER</u>?

_____

How would you describe your pain?

❑ Aching	❑ Dull	❑ Stiffness
❑ Sharp	❑ Piercing	❑ Stabbing
❑ Burning	❑ Pulling	❑ Throbbing
❑ Numbness	❑ Pins/Needles	

❑ **Other:** _____

Place a check in the box that describes the severity of your pain.

	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

Have you experienced any of the following symptoms in the past <u>2 Weeks</u>?

❑ None

	❑ Diarrhea ❑ Constipation
❑ Fatigue	❑ Rash
❑ Fever	❑ Dizziness
❑ Ear Pain	❑ Extremity Numbness
❑ Sore Throat	❑ Problems walking
❑ Sinus pain/pressure	❑ Headache
❑ Changes in Vision	❑ Anxiety ❑ Depression
❑ Cough	❑ Insomnia
❑ Shortness of breath	❑ Back Pain
❑ Chest Pain	❑ Joint Pain
❑ Edema/Ankle Swelling	❑ Joint swelling
❑ Palpitations	❑ Morning stiffness
❑ Painful urination	❑ Muscle weakness
❑ Urinary incontinence	❑ Neck Pain
❑ Abdominal Pain	
	❑ Other: _____

Have you seen any other providers relating to the problem recently? ❑ Yes ❑ No

Who?_____

Have you had any tests performed for this problem?

❑ Lab tests ❑ X-Ray ❑ CT Scan ❑ MRI ❑ Other

Other Problems since last visit?

_____

New medications since last visit? ❑ Yes ❑ No

Any changes in your job or family? ❑ Yes ❑ No

Additional information: _____

_____

❑ Patient Hx above was reviewed today

❑ Recent Hx and physical exams were reviewed today **Physician's Signature:** _____

Physician Documentation (SOAP)

Date:_____

Subjective:_____

_____

_____

_____

_____

_____

Objective:_____

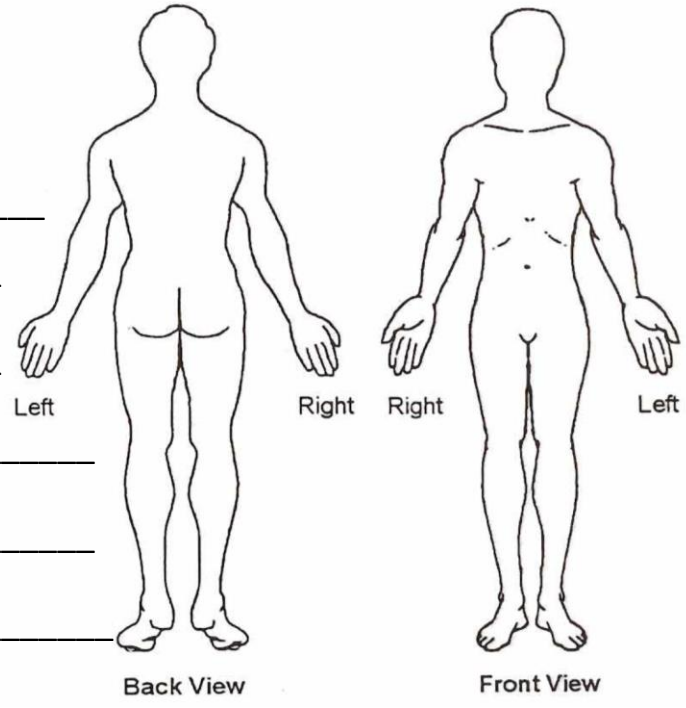
_____

_____

_____

_____

_____



Assessments: _____

_____

_____

_____

Regional Dysfunctions: H C T R L S P UE LE Ab

Plans: _____

_____

_____

_____

_____

Physician Signature: _____