Omaha Health Therapy Center, LLC

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Sex: ____ Home Phone: _____ Mobile Phone: _____

Email: _____ How did you find us? _____

Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____

Please list ALL active treating physicians (i.e pulmonologist, oncologist, internist, cardiologist, etc)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

General Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems..... o Y o N
Arthritis..... o Y o N
Bleeding/Clotting Disorder..... o Y o N
Blood Pressure Disorder..... o Y o N
Blood Transfusion..... o Y o N
Bowel/Stomach Problems ..... o Y o N
Cancer ..... o Y o N
Cholesterol Disorder ..... o Y o N
Diabetes ..... o Y o N
Eye Disorder (i.e. Glaucoma) ..... o Y o N
Relevant Gynecological Issues ..... o Y o N

Heart Disease/Disorder..... o Y o N
Lung Disorder..... o Y o N
Liver Disease..... o Y o N
Neurological Disorder/Chronic Headaches o Y o N
Psychiatric Disorder/Illness..... o Y o N
Pulmonary Embolism/DVT ..... o Y o N
Stroke ..... o Y o N
Seizure or Epilepsy ..... o Y o N
Thyroid Disorder ..... o Y o N
Urinary/Kidney Disorder ..... o Y o N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□Y □N	
Father		□Y □N	
Sibling		□Y □N	
Other:		□Y □N	

Do you currently smoke? □Y □N If no, previously? □Y □N Years smoked Packs/day

Do you use other tobacco products? □Y □N Consume alcohol? □Y □N If yes, drinks/week:

If Relevant: Any past pregnancies? □Y □N How many? ___ How many deliveries? ___

Constitutional

☐Y☐N Fever	☐Y☐N Fatigue	☐Y☐N Weight Gain (___ Lbs)	☐Y☐N Sleep Disturbances
☐Y☐N Chills	☐Y☐N Feeling Poorly	☐Y☐N Weight Loss (___ Lbs)	☐ Other:
	☐Y☐N Sweats	☐Y☐N Unexp. Weight Change	

Head, Eyes, Ears, Nose, and Throat

☐Y☐N Vision Problem	☐Y☐N Red Eyes	☐Y☐N Congestion	☐Y☐N Hoarseness
☐Y☐N Decreased Hearing	☐Y☐N Eye Pain	☐Y☐N Snoring	☐Y☐N Ringing in Ears
☐Y☐N Double Vision	☐Y☐N Runny Nose	☐Y☐N Dry Mouth	☐Y☐N Vertigo
☐Y☐N Light Sensitivity	☐Y☐N Neck Stiffness	☐Y☐N Flu-Like Symptoms	☐Y☐N Earache
☐Y☐N Itchy Eyes	☐Y☐N Nosebleed	☐Y☐N Sore Throat	☐Y☐N Other:

Cardiovascular

☐Y☐N Chest Pain	☐Y☐N Cold Extremities	☐Y☐N Irregular Heart Rhythm
☐Y☐N Palpitations	☐Y☐N Cold Hands or Feet	☐Y☐N Other:
☐Y☐N Leg Swelling	☐Y☐N Leg Pain w/ Walking	

Respiratory

☐Y☐N Shortness of Breath	☐Y☐N Wheezing	☐Y☐N Coughing Up Blood	☐
☐Y☐N Cough	☐Y☐N Shortness of Breath	☐Y☐N Coughing Up Sputum	
☐Y☐N Rapid Breathing	☐Y☐N Chest Congestion	☐ Other:	

Gastrointestinal

☐Y☐N Abdominal Pain	☐Y☐N Diarrhea	☐Y☐N Change in Bowels	☐Y☐N Painful Swallowing
☐Y☐N Blood in Stool	☐Y☐N Black/Tarry Stools	☐Y☐N Vomiting Blood	☐ Other:
☐Y☐N Vomiting	☐Y☐N Decreased Appetite	☐Y☐N Bowel Incontinence	
☐Y☐N Nausea	☐Y☐N Yellow Skin	☐Y☐N Rectal Pain	
☐Y☐N Constipation	☐Y☐N Trouble Swallowing	☐Y☐N Heartburn	

Integumentary

☐Y☐N Rash	☐Y☐N Skin Wound	☐Y☐N Unusual Growth	☐Y☐N Skin Cancer
☐Y☐N Dry Skin	☐Y☐N Change in A Mole	☐Y☐N Itching	☐ Other:

Psychiatric

☐Y☐N Depression	☐Y☐N Anxiety	☐Other:

Hematologic/Lymphatic

☐Y☐N Easy Bruising	☐Y☐N Easy Bleeding	☐Y☐N Swollen Lymph Nodes	☐ Other:

Endocrine

☐Y☐N Excessive Thirst	☐Y☐N Heat Intolerance	☐Y☐N Changes- Skin
☐Y☐N Cold Intolerance	☐Y☐N Changes- Hair	☐ Other:

Neurological

☐Y☐N Headache	☐Y☐N Unsteady	☐Y☐N Numbness	☐Y☐N Tremor
☐Y☐N Dizziness	☐Y☐N Disorientation	☐Y☐N Tingling	☐Y☐N Memory Lapses/Loss
☐Y☐N Decreased Strength	☐Y☐N Confusion	☐Y☐N Seizures	☐ Other:
☐Y☐N Poor Coordination	☐Y☐N Burning Sensation	☐Y☐N Fainting (Syncope)	

Musculoskeletal

☐Y☐N Joint Pain	☐Y☐N Limb Pain	☐Y☐N Muscle Pain	☐ Other:
☐Y☐N Neck Pain	☐Y☐N Joint Swelling	☐Y☐N Muscle Weakness	
☐Y☐N Back Pain	☐Y☐N Muscle Cramps	☐Y☐N Leg Swelling	

Genitourinary

☐Y☐N Frequent Urination	☐Y☐N Pelvic Pain	☐Y☐N Painful Intercourse	☐Y☐N Heavy Period Bleeding
☐Y☐N Incontinence	☐Y☐N Nocturia	☐Y☐N Discharge- Vaginal	☐ Other:
☐Y☐N Urinary Urgency	☐Y☐N Itching- Genital	☐Y☐N Vaginal Bleeding	
☐Y☐N Painful Urination	☐Y☐N Change in Libido	☐Y☐N Irreg. Monthly Cycles	

Reason for today's visit: _____

Which side hurts? ☐ *Left* ☐ *Right* ☐ *Both* **How long has your reason for today's visit been going on?** _____

How did it start? _____

Hand dominance: ☐ *Left* ☐ *Right*

Pain description: ☐ *Dull* ☐ *Sharp* ☐ *Tingling* ☐ *Other:* _____

When does pain occur? ☐ *At rest* ☐ *With activity* ☐ *At night* ☐ *Other:* _____

Rate pain: *(Check box)*

No pain	1	2	3	4	5	6	7	8	9	10	Most extreme
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

What reduces the pain? ☐ *Medicine* ☐ *Ice* ☐ *Heat* ☐ *Rest* ☐ *Elevation*

Your problem has: ☐ *Improved* ☐ *Worsened*

Any other symptoms associated with the current problem? _____

Does your home have: *(Check all that apply)* ☐ *1 story* ☐ *2 stories* ☐ *3+ stories* ☐ *Entrance steps* ☐ *Elevator*

Name of person completing form: _____ Relationship (if not patient): _____

Referring provider's name: _____ Phone number: _____

Address: _____ Fax number: _____

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Primary care provider's name: _____ Phone number: _____

Address: _____ Fax number: _____

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*