OSTEOPATHIC HEALTHCARE OF MAINE
ADULT HISTORY

NAME:_____ DATE:_____

DOB:_____ AGE:_____ M/F:_____

CURRENT STATUS

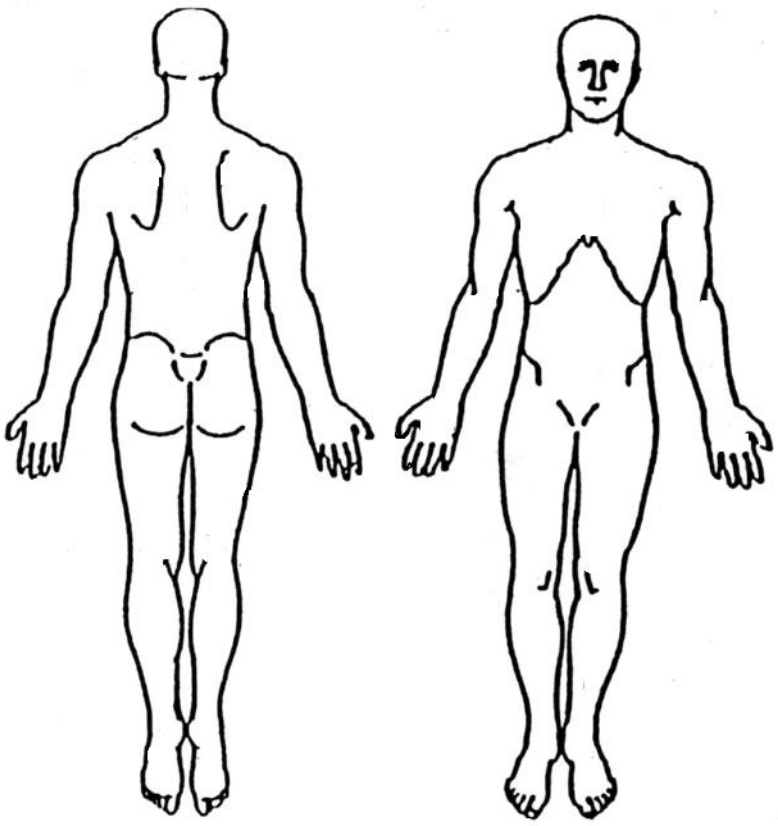
PRIMARY PROBLEMS

1._____ 3._____
2._____ 4._____

SYMPTOM DRAWING

Please mark the areas on the diagrams below where you feel these symptoms, using the codes indicated. Include all the affected areas.

ACHE	SHARP	NUMB	BURNING	PRESSURE	TIGHT/STIFF	TINGLING
~~	>>>>	oooo	xxxx	++++	/////	****
~~	>>>>	oooo	xxxx	++++	/////	****



How bad is your pain on an average day?

None_____Worst

0 1 2 3 4 5 6 7 8 9 10

Problem	Location	Date of onset	Was the onset Sudden?	Gradual?
1.				
2.				
3.				
4.				

Occurs how often and for how long?	At what times of day and with what activities, is it Worse?	Better?
1.		
2.		
3.		
4.		

Causes: **MVA ___ Work injury ___ Computer use ___ Fall ___ Bend ___ Twist ___ Lift ___ Push/Pull ___ Sport injury ___ Other trauma___ Allergy___ Infection___ Unknown___**
Other_____

Please describe the causes:_____
_____

Are you getting: Better ____ Worse ____ No change ____ Unsure ____

PRIOR TREATMENT NONE:___

Healthcare Provider	Dates	Diagnosis	Treatment Plan
1.			
2.			
3.			
4.			
5.			

	Better	Worse	No Change
Heat:	____	____	____
Ice:	____	____	____
Rest:	____	____	____
Sitting:	____	____	____
Standing:	____	____	____
Activity:	____	____	____
Exercise:	____	____	____
Stretching:	____	____	____
Strengthening:	____	____	____
Massage:	____	____	____
PT/OT:	____	____	____
Osteopathic Treatment:	____	____	____

	Better	Worse	No Change
Chiropractic:	____	____	____
Braces:	____	____	____
Orthotics/Lifts:	____	____	____
Injections:	____	____	____
Surgery:	____	____	____
Acupuncture:	____	____	____
Counseling:	____	____	____
Biofeedback:	____	____	____
Anti-Inflammatory:	____	____	____
Muscle relaxant:	____	____	____
Narcotics:	____	____	____
Antidepressant:	____	____	____
Other:	____	____	____

DIAGNOSTIC TESTS NONE:___

	Dates	Body Area	Results
X-Ray:	_____	_____	_____
CAT Scan:	_____	_____	_____
MRI:	_____	_____	_____
Bone Scan:	_____	_____	_____
EMG:	_____	_____	_____
Bone Density:	_____	_____	_____
EEG:	_____	_____	_____
Labs:	_____	_____	_____
Other:	_____	_____	_____

PAST MEDICAL HISTORY
(Please give details and approximate dates)

TRAUMA NONE:___

1. **Head trauma/concussion:** _____
2. **Motor vehicle accidents:** _____
3. **Injuries (sports, falls, etc):**_____
4. **Physically demanding activities (sport/arts/crafts etc):** _____
5. **Dental work (extractions, braces, etc):**_____
6. **Injuries from giving birth:** _____
7. **Injuries during your birth:** _____
8. **Emotional trauma:** _____
9. **Other:**_____

ILLNESS/DISEASE PROCESS NONE:___

1. **Arthritis:** _____
2. **Torn ligaments:**_____
3. **Tendonitis:**_____
4. **Carpal Tunnel Syndrome:**_____
5. **Disc disease:** _____
6. **Short leg:** _____
7. **Lyme Disease:** _____
8. **Fibromyalgia:** _____
9. **Chronic Fatigue Synd.:** _____
10. **ADD/ADHD:** _____
11. **Depression/anxiety:**_____
12. **Anorexia:**_____
13. **Obesity:**_____
14. **Thyroid disease:** _____
15. **Trigeminal Neuralgia:**_____
16. **Bell's Palsy:**_____
17. **Meniere's Disease:**_____
18. **Diabetes Mellitus:** _____
19. **Cancer:** _____
20. **HIV/AIDS:** _____
21. **High Cholesterol/Triglycerides:**_____
22. **Other Important Illness :**_____

REPRODUCTIVE HISTORY NONE:___

Pregnancies: Number___ Term___ Premature___ Abortions/Miscarriages____ Living___

	1st Child	2nd Child	3rd Child	4th Child
Prenatal problems:	_____	_____	_____	_____
Duration of labor/pushing:	_____	_____	_____	_____
Delivery type:	_____	_____	_____	_____
Procedures/Complications:	_____	_____	_____	_____
Postpartum problems:	_____	_____	_____	_____

SURGICAL HISTORY NONE:___

Disc/Laminectomy____ Fracture repair___ Ligament repair___ Torn cartilage___ Scoliosis___
Spinal fusion___ Joint repair/replacement___ C-Section___ Gallbladder___ Appendix___ Prostate___
Breast___ Sinus___ Ear___ Nose___ Tonsils/adenoids___ Dental___ Angioplasty___ Bypass___
Laparoscopic procedures___ Cosmetic___ Other_____-
_____

HOSPITALIZATIONS NONE:___

Hospital	Dates	Diagnosis	Treatment
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

MEDICATIONS NONE:___

Please list all medications including dose and number of times taken per day. Include prescriptions, vitamins, supplements, remedies, ect:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES/SENSITIVITIES NONE:___

Please list any reactions you have to medications, foods, the environment, or chemicals:
_____
_____
_____

SOCIAL HISTORY

HOME ENVIRONMENT

Who lives in your home?:_____
Environmental exposures (including smokers, pets):_____**NONE:**___
Quality of home life:_____

WORK ENVIRONMENT NONE:___

Job title/duties:_____
Responsibilities/Satisfaction:_____
Physical demands/Ergonomics:_____

HABITS

	Amount	Frequency	# Years	When Quit	Never
Smoking:	_____	_____	_____	_____	___
Alcohol:	_____	_____	_____	_____	___
Drugs:	_____	_____	_____	_____	___
Caffeine:	_____	_____	_____	_____	___

HEALTH MAINTENANCE

Physical activity (type/frequency):_____NONE:___
Stretching (type/frequency):_____NONE:___
Hobbies/Recreation (type/frequency):_____NONE:___
Nutrition (protein/veggies/carbs/fruits/snacks/sugar):_____
_____
_____
Fluid intake (type, amount/day):_____
Sleep/Rest (hours/day, quality):_____

FAMILY HISTORY

	Age	Health status	Death/cause/age
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

If you have any relatives with problems similar to your "Primary Problems" please identify them and the problems: NONE:___
_____
_____

HEALTH PROBLEMS (in any blood relative) NONE:___

Chronic back pain___ Ruptured discs___ Back or joint surgery___ Fibromyalgia____ CFIDS___ Thyroid disease___ Depression___ Anxiety___ ADD___ Lyme Disease___ Eating disorder___ Obesity___ Substance abuse___ Other_____

OTHER INFORMATION

Is there anything else you would like to share?: NONE:___
_____

REVIEW OF SYSTEMS NONE:___

Please Check and Circle ALL that apply

General
( ) Weight gain or loss, change in appetite/thirst
( ) Fatigue, weakness, change in sleep pattern
( ) Fever, chills, night sweats, cold intolerance
( ) Change in quality of hair/skin, easy bruising
( ) High Cholesterol +/o Triglycerides

Head, eyes, ears, nose and throat
( ) Eye pain/disease, visual problems
( ) Ear pain/infections/ringing, hearing problems
( ) Chronic sinusitis, nasal discharge
( ) Sore throat, change in voice
( ) Difficulty swallowing

Skin
( ) Itching, burning, rashes (psoriasis, eczema, etc)
( ) Lumps, tumors, cancer
( ) Changes in moles/warts/lesions

Cardiovascular
( ) Chest pain, heart attack, angina
( ) Palpitations, arrhythmia, heart murmurs
( ) Blood vessel disease, clots, thrombophlebitis
( ) Foot/Ankle swelling, heart failure
( ) High blood pressure

Respiratory
( ) Wheeze, asthma, use of inhalers
( ) Shortness of breath – with activity/at rest
( ) Frequent cough, bronchitis, COPD
( ) Pneumonia, flu, RSV

Gastrointestinal
( ) Nausea/Vomiting, abdominal pain, ulcer
( ) Heartburn, reflux, hiatal hernia
( ) Change in bowel habits: freq., color, consistency
( ) Irritable bowel synd., excessive gas, food intol.
( ) Inflammatory Bowl Disease: Crohn's, Ulc. Colitis
( ) Liver/Gallbladder disease

Urinary
( ) Sexually transmitted diseases
( ) Frequent UTI, pain w/urinating
( ) Incontinence or difficulty urinating
( ) Kidney stones, tumors, proceedures

Nervous System
( ) Seizures, tremors
( ) Headache, head injury
( ) Numbness, tingling
( ) Loss of coordination
( ) Dizziness/Vertigo
( ) Poor memory or concentration
( ) Stroke, TIA, fainting
( ) Change in taste, smell
( ) Neurologic disease, i.e., MS

Musculoskeletal system
( ) Joint pain, redness, swelling, stiffness
( ) Frequent/severe muscle pain/weakness
( ) Disc herniation
( ) Short leg syndrome
( ) Abnormal curvature of the spine
( ) Worker's Comp injuries

Psychological
( ) Often nervous/worried
( ) Post traumatic stress disorder
( ) Constant feelings of sadness or hopelessness
( ) Hospitalized for mental illness
( ) Psychological diagnosis

FEMALE Endocrine/Reproductive
( ) Decreased sense of well-being, decreased energy
( ) Decreased mental sharpness/indecisiveness
( ) Sexual dysfunction: decreased desire, pain
( ) Menstrual irregularity: flow, bloating, PMS
( ) Endometriosis, fibroids
( ) Infertility, miscarriages
( ) Menopausal, Peri-Menopausal
( ) Breast lumps/cysts/tumors, nipple discharge
( ) Osteopenia/osteoporosis

MALE Endocrine/Reproductive
( ) Decreased sense of well-being, decreased energy
( ) Decreased mental sharpness/indecisiveness
( ) Erectile Dysfunction
( ) Sexual dysfunction: desire, pain, infertility
( ) Loss of muscle mass, strength
( ) Prostate disease

Other Problems (not listed above):_____**NONE:**___

History Reviewed (Date and Initial) **1.**_____ **2.**_____ **3.**_____
***Osteopathic Principles and Practice Discussed*: ___**