

**OSTEOPATHIC HEALTHCARE OF MAINE**  
**ADULT HISTORY**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DOB: \_\_\_\_\_

AGE: \_\_\_\_\_

M/F: \_\_\_\_\_

**CURRENT STATUS**

**PRIMARY PROBLEMS**

1. \_\_\_\_\_

3. \_\_\_\_\_

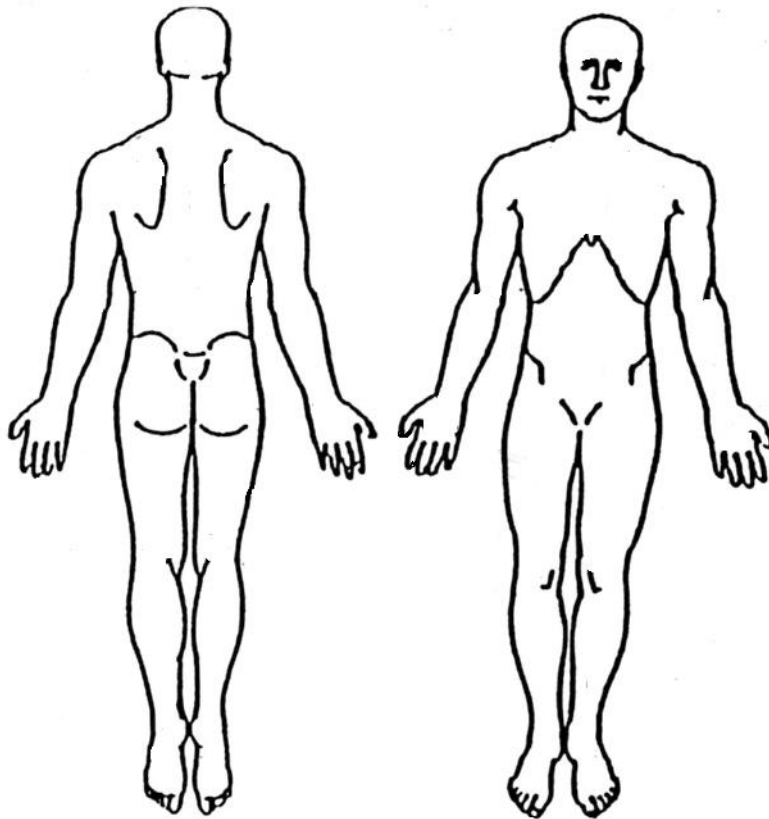
2. \_\_\_\_\_

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.

<u>ACHE</u>	<u>SHARP</u>	<u>NUMB</u>	<u>BURNING</u>	<u>PRESSURE</u>	<u>TIGHT/STIFF</u>	<u>TINGLING</u>
~~~~	>>>>	0000	XXXX	++++	////	****
~~~~	>>>>	0000	XXXX	++++	////	****



How bad is your pain on an average day?

None \_\_\_\_\_ Worst  
0 1 2 3 4 5 6 7 8 9 10

	<u>Problem</u>	<u>Location</u>	<u>Date of onset</u>	<u>Was the onset</u>	
				<u>Sudden?</u>	<u>Gradual?</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

	<u>Occurs how often and for how long?</u>	<u>At what times of day and with what activities, is it</u>	
		<u>Worse?</u>	<u>Better?</u>
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:** \_\_\_

	<u>Healthcare Provider</u>	<u>Dates</u>	<u>Diagnosis</u>	<u>Treatment Plan</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

	<u>Better</u>	<u>Worse</u>	<u>No Change</u>		<u>Better</u>	<u>Worse</u>	<u>No Change</u>
Heat:	_____	_____	_____	Chiropractic:	_____	_____	_____
Ice:	_____	_____	_____	Braces:	_____	_____	_____
Rest:	_____	_____	_____	Orthotics/Lifts:	_____	_____	_____
Sitting:	_____	_____	_____	Injections:	_____	_____	_____
Standing:	_____	_____	_____	Surgery:	_____	_____	_____
Activity:	_____	_____	_____	Acupuncture:	_____	_____	_____
Exercise:	_____	_____	_____	Counseling:	_____	_____	_____
Stretching:	_____	_____	_____	Biofeedback:	_____	_____	_____
Strengthening:	_____	_____	_____	Anti-Inflammatory:	_____	_____	_____
Massage:	_____	_____	_____	Muscle relaxant:	_____	_____	_____
PT/OT:	_____	_____	_____	Narcotics:	_____	_____	_____
Osteopathic Treatment:	_____	_____	_____	Antidepressant:	_____	_____	_____
				Other:	_____	_____	_____

**DIAGNOSTIC TESTS**      **NONE:** \_\_\_\_\_

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

**REPRODUCTIVE HISTORY**      **NONE:** \_\_\_\_\_

Pregnancies:    Number \_\_\_\_\_    Term \_\_\_\_\_    Premature \_\_\_\_\_    Abortions/Miscarriages \_\_\_\_\_    Living \_\_\_\_\_

	<b><u>1st Child</u></b>	<b><u>2nd Child</u></b>	<b><u>3rd Child</u></b>	<b><u>4th Child</u></b>
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:** \_\_\_\_\_

	<u>Hospital</u>	<u>Dates</u>	<u>Diagnosis</u>	<u>Treatment</u>
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**

	<u>Amount</u>	<u>Frequency</u>	<u># Years</u>	<u>When Quit</u>	<u>Never</u>
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**

	<u>Age</u>	<u>Health status</u>	<u>Death/cause/age</u>
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 +/- 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 Bowel Disease: Crohn's, Ulc. Colitis
- Liver/Gallbladder disease

Urinary

- Sexually transmitted diseases
- Frequent UTI, pain w/urinating
- Incontinence or difficulty urinating
- Kidney stones, tumors, procedures

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: