Dr. Vanessa Newman, DO

Osteopathic Physician

902 Sante Fe

New Patient Intake Form

Welcome to our practice!

Today's Date: _____

Patient Name: _____ Date of Birth _____ Age: _____

Preferred Gender Pronouns: _____

Address(s): _____

_____

Home Phone(s): _____ Cell Phone(s): _____

Email Address(s): _____

Best place(s) to leave messages: ☐ Home ☐Cell

Number in household: _____

Children: _____ Occupation: _____

Employer: _____

Will you be submitting bills to an insurance carrier for reimbursement? ☐Yes ☐N0; If yes: ☐Health or ☐Auto Insurance

Insurance Carrier: _____ Name on Policy: _____

Policy Holder DOB: _____-_____-_____

Please indicate if you receive coverage through:

☐ Disability ☐ Work Comp ☐ Medicare

Emergency Contact: _____

Relationship: _____ Phone: _____

Referred by: _____

Reason for your visit today (please feel free to include a timeline on the back of this sheet if helpful):

_____

_____

_____

_____

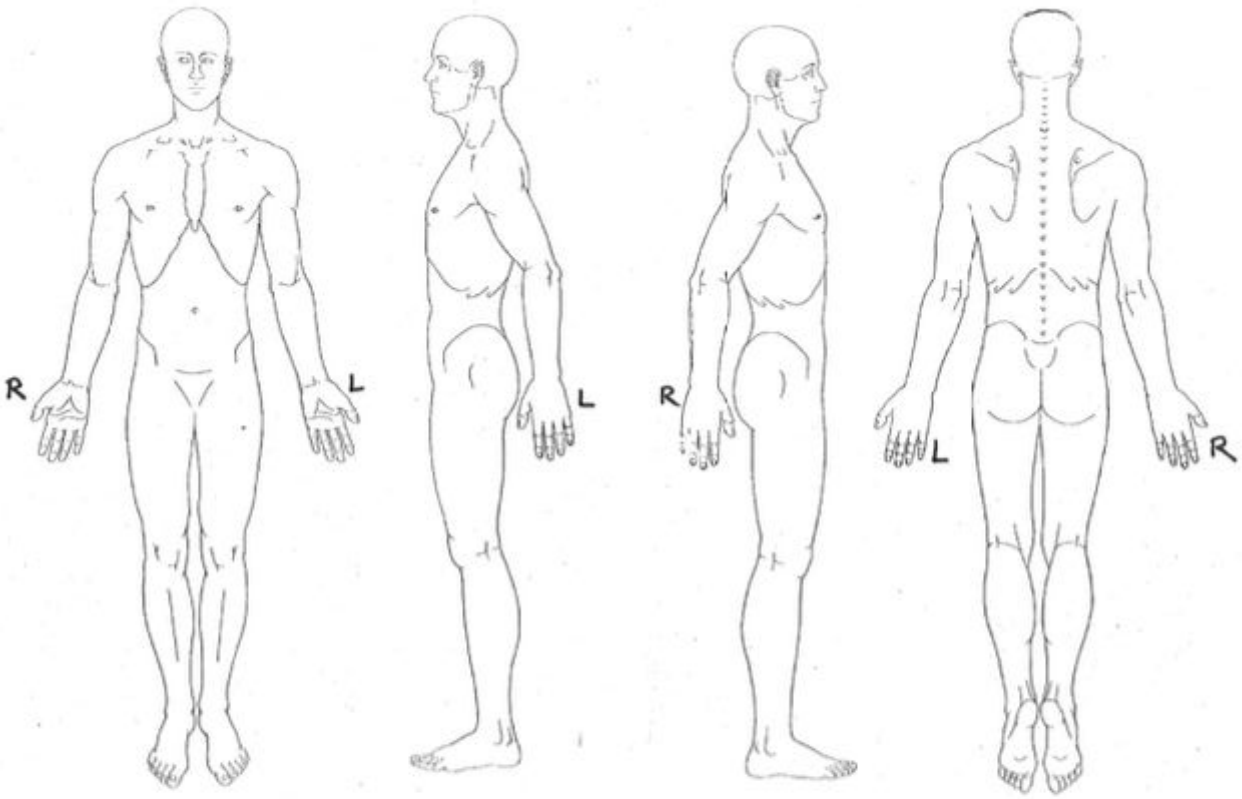
_____

_____

Was there an inciting event, or anything different in your life, 6-12 months before this concern began?

_____

_____



Please mark areas of pain/concern with an X.

Circle any areas of numbness/tingling.

Family History – Did any blood relative suffer any of the following? (Please indicate the following: M = mother; F = father; B = brother; S = sister; MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather)

_____ ☐ Epilepsy	___ ☐ Asthma	___ ☐ High cholesterol
_____ ☐ Migraine	___ ☐ Anemia	___ ☐ Alcoholism
_____ ☐ Mental Illness	___ ☐ Bleeds easily	___ ☐ Hepatitis
_____ ☐ Glaucoma	___ ☐ Osteoporosis	___ ☐ Cancer
_____ ☐ Diabetes	___ ☐ Arthritis	___ ☐ _____
_____ ☐ Thyroid	___ ☐ Heart disease	___ ☐ _____
_____ ☐ Hay fever	___ ☐ Hypertension	___ ☐ _____

Allergies (drugs, foods, environmental):

_____

Primary Care Physician and other healthcare practitioner(s) from whom you are *currently* receiving medical care:

Physician/ Practitioner	Condition being treated	Medications/Supplements

Please list all major medical problems/illnesses, surgeries, including major dental work and hospitalizations (indicate year/age, may continue on back as needed)

Year/age	

Describe all car accidents, injuries, head injury, falls, fractures or broken bones (include year/age occurred, may continue on back):

Year/age	

SOCIAL AND DIET HISTORY

Occupation(s) _____ Relationship status _____ # of Children _____
Exercise/Recreation/Hobbies_____
_____

Significant Sources of Stress
_____

Smoking (type & amount per day)_____ If ex-smoker, date quit_____

Other drugs (type & amount per day) _____

Alcohol (amount per week)_____ Caffeine (type & amount per day)_____ Sodas per week _____

Dietary Restrictions/Preferences_____

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Glasses of water per day _____ Date of Last Dental Exam_____

YOUR OWN BIRTH HISTORY (as much as possible)

Please Circle: Full-Term Premature Late Vaginal Delivery Cesarean Section
Forceps/Vacuum Number of Older Siblings_____ Number of Younger Siblings_____ Birth Weight _____
Complications/Interventions:_____

MEDICAL HISTORY

☐ Decreased hearing
☐ Ringing in ear
☐ Ear infections
☐ Dizzy or fainting spells
☐ Failing vision or eye pain
☐ Double or blurred vision
☐ Nose bleeds – recurrent
☐ Sinus trouble
☐ Sore throats – frequent
☐ Hoarseness – prolonged
☐ Hayfever /Allergies
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath
☐ On exertion ☐ Lying flat
☐ Chest pain
☐ High blood pressure
☐ Heart murmur
☐ Swollen ankles
☐ Irregular pulse
☐ Palpitations
☐ Leg pain when walking
☐ Varicose veins / Phlebitis
☐ Cold numb feet
☐ Loss of appetite - recent
☐ Eating disorder
☐ Difficulty swallowing
☐ Heartburn
☐ Peptic ulcer
☐ Persistent Nausea / vomiting
☐ Abdominal Pain - chronic
☐ Gallbladder trouble
☐ Jaundice / Hepatitis
☐ Diarrhea ☐Constipation
☐ Diverticulosis ☐ Crohn's / Colitis
☐ Inflammatory Bowel Syndrome

Bloody or tarry stool
☐ Hemorrhoids
☐ Hernia
☐ Urination / Overactive bladder
☐ Overnight more than twice
☐ More than 8 times / 24 hrs
☐ Urgency to urinate
☐ Decrease in force/flow ☐ Painful
☐ Stress incontinence – urine leakage with exercise /movement
☐ Blood in urine ☐ Kidney stones
☐ Urine infections – frequent
☐ Sexually transmitted diseases
☐ Sexual concerns
☐ Weight loss ☐ Gain – recent
☐ Anemia ☐ Bruise easily
☐ Blood transfusions
☐ Cancer
☐ Chronic fatigue
☐ Diabetes
☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Numbness / tingling sensations
☐ Headaches – frequent
☐ Arthritis / Rheumatism
☐ Back pain – recurrent
☐ Bone fracture / joint injury
☐ Osteoporosis/Osteopenia
☐ Foot pain ☐ Gout
☐ Unusual moles ☐ Rashes
☐ Hives ☐ Psoriasis ☐ Eczema
☐ Any type of sleeping difficulty
☐ Snoring/Mouth breathing
☐ Depression ☐ Nervousness
☐ Agitation ☐ Memory loss
☐ Moodiness ☐ Phobias

☐ Suicidal thought ☐ Mental illness
☐ Feelings of worthlessness
☐ Rheumatic fever
☐ Scarlet fever ☐ Mumps
☐ Chickenpox ☐ Polio
☐ Measles ☐ German measles
☐ Tuberculosis ☐ Herpes
☐ AIDS / HIV
☐ Acupuncture / tattoos
☐ Hair loss ☐ Progressive
☐ Recent

MALES: ☐ Prostate problems

FEMALES *Please complete:*
Menstrual Flow:
Age of onset _____
☐ Regular ☐ Irregular
☐ Pain/Cramps
Days of flow _____
Length of cycle _____
Date of 1st day of last period_____
☐ Pain / Bleeding during or after sex
Number of Pregnancies ____
Live Births:
Term_____ Preterm_____
Abortions ____
Miscarriages ____
Birth control method_____
☐ Flushing / Menopause
Date of last PAP test
_____☐ Normal ☐ Abnormal
Date of last mammogram
_____☐ Normal ☐ Abnormal

Routine labs-- date of most recent: _____

Indicate any abnormal results: _____

Previous imaging/X-Rays: (Body Region and Reason for test)

X-ray _____

MRI _____

CT Scan _____

Sonogram _____

Other procedures: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my health. I also authorize the healthcare providers to perform the necessary health care services I may need, including Osteopathic Manipulation.

Signature_____Date_____