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Osteopathic Manipulative Treatment
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Please fill out as much as possible of your contact information and medical history. Read the HIPPA/Privacy agreement. You will need to sign the Medicare Agreement if applicable in the office and you may read it in advance on our website here.   Once you fill out this form and print it to PDF, please email it to us a few days prior to your first visit.

Registration Information

Date:

Name: Preferred Pronouns:

Address:

City: State: Zip Code:

Birth Date: Gender:

Occupation:

Emergency Contact including Phone Number:

Indicate best number to reach you for last minute cancellations:

☐ Cell phone: ☐ Home phone: ☐ Work phone:

Email:

Which do you prefer for appointment confirmations:

☐ text (you must reply to the opt-in message), ☐ voicemail, or ☐ email?

(If you do not receive an automated reminder a few days before each appointment, please call/text (415-255-5729) or email (info@do-sf.com) to make sure you are on the calendar. If you are offered an appointment via text or email and you accept it, your appointment is not set until you receive a reply from Carolina confirming it.)

HEALTH HISTORY QUESTIONNAIRE

For any answers requiring more space, continue on page 7 or attach your own document or timeline as indicated, and attach all relevant imaging reports/labs with dates.

Today's Date:

Name: | **Gender:** | **DOB:**

Referred by: | **Primary Care Provider:**

WHAT IS THE MAIN REASON(S) YOU ARE SEEKING TREATMENT?

PERSONAL HEALTH HISTORY

List all medical problems (include year of onset)

Surgeries/Procedures/Major Dental Work (include year), including all injections

Hospitalizations (other than those associated with surgeries/procedures listed above, include year and diagnosis)

List your prescribed drugs and over-the-counter medications, supplements, and herbs (include strength and how often you take them)

Allergies to medications, foods, environment (include the reaction you had)

Primary Care Provider (primary care is not provided at this office. Patients should have a primary care physician for general medical needs)**, other physicians seen** (note their specialties)**, as well as other therapists** (including massage, acupuncture, chiropractic, etc.)

Traumas, Injuries, Accidents, Broken Bones, Head Injuries, indicating any time of loss of consciousness (include year and diagnosis) as well as PTSD, assaults, abuse or other emotional traumas.

Your Own Birth History (as much as possible)

Pregnancy: ☐ Full term ☐ early ☐ late Type of Delivery: ☐ Vaginal ☐ C-Section ☐ Forceps used? Birth Weight:

Number of older siblings: Number of younger siblings:

Any other Complications?

Obstetric history (women only)

Number of pregnancies: Number of full term births: Number of premature births: Number of miscarriages/abortions:

List any issues or complications for each pregnancy/delivery including back pain, difficult labor, induction, epidural, vacuum or forceps, scheduled vs. emergency C-Sections, as well as difficulties for the baby.

Hypermobility Screen	Can you (or could you ever) place your hands flat on the floor without bending your knees?	☐	Yes
	Can you (or could you ever) bend your thumb to touch your forearm?	☐	Yes
	As a child could you contort your body into strange shapes OR do the splits?	☐	Yes
	As a child or teenager did your shoulder or kneecap dislocate on more than one occasion?	☐	Yes
	Do you consider yourself double-jointed?	☐	Yes
Osteoporosis Risk Factors	Do you have a small/thin frame?	☐	Yes
	Are you Caucasian or Asian?	☐	Yes
	Have you had broken bones in adulthood without significant trauma?	☐	Yes
	Are you postmenopausal?	☐	Yes
	Do you experience early or induced menopause?	☐	Yes
	Have you been on high doses thyroid medicines?	☐	Yes
	Have you taken steroids for longer than 3 months?	☐	Yes
	Have you been on chemotherapy/Immunosuppressive medicine?	☐	Yes
	Do you have a sedentary lifestyle?	☐	Yes
	Are you or have you ever smoked regularly?	☐	Yes
	Do you regularly (or have you ever) drink >4 Alcoholic Beverages per Week	☐	Yes

SOCIAL HISTORY							
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	Gender of partner:
Type of exercise and frequency:							
List any dietary restrictions/preferences:							

☐ No caffeinated drinks	☐ Tea	☐ Coffee	☐ Cola	☐ other	
# of cups/cans per day?					

Do you drink alcohol?	☐ Yes
If yes, what kind?	
How many drinks per week?	
Do you use or have you ever used tobacco?	☐ Yes
☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day	
# of years Or year quit	
Do you currently use recreational drugs?	☐ Yes
Have you ever given yourself street drugs with a needle?	☐ Yes
Are you sexually active?	☐ Yes
If yes, are you trying for a pregnancy?	☐ Yes
If not trying for a pregnancy list contraceptive used:	
Is stress a major issue for you? Major stressors:	☐ Yes
Do you have trouble sleeping?	☐ Yes
If yes, do you have trouble: ☐ falling asleep ☐ staying asleep Avg. hours per night?	

FAMILY HEALTH HISTORY

	BIRTH YR/GENDER	SIGNIFICANT HEALTH PROBLEMS		BIRTH YR/GENDER	SIGNIFICANT HEALTH PROBLEMS
Mother			**Children**		
Father					
Sibling					
			Grandmother *Maternal*		
			Grandfather *Maternal*		
			Grandmother *Paternal*		
			Grandfather *Paternal*		

WOMEN ONLY

Date of last menstruation: Age at onset of menstruation:		
How many days does your menstruation last? . How many days do your cycles last?		
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes
Are you currently pregnant or breastfeeding?	☐	Yes
Have you had a D&C, hysterectomy, or Cesarean?	☐	Yes
Any discomfort with intercourse?	☐	Yes
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes
Any blood in your urine?	☐	Yes
Any problems with control of urination?	☐	Yes
Any hot flashes or sweating at night?	☐	Yes
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes
Date of last Pap exam? Any abnormalities in the past?	☐	Yes

MEN ONLY

Do you usually get up to urinate during the night?	☐	Yes
If yes, # of times:		
Do you feel pain or burning with urination?	☐	Yes
Any blood in your urine?	☐	Yes
Do you feel burning discharge from penis?	☐	Yes
Has the force of your urination decreased?	☐	Yes
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes
Do you have any problems emptying your bladder completely?	☐	Yes
Any difficulty with erection or ejaculation?	☐	Yes
Any testicle pain or swelling?	☐	Yes
Date of last rectal/prostate exam?		

OTHER PROBLEMS
List any symptoms or problems that you have had in the following areas to a significant degree and briefly explain.

Skin	Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Stomach	Energy level
Nose/Sinuses	Intestines	Ability to sleep
Throat	Bladder	Other pain/discomfort:
Lungs	Circulation	Temperature Sensitivity

Current Height: ______ and Current Weight: ______

Dates of Most Recent Tests (check box if abnormal and provide labs/reports)

☐ Cholesterol Panel: ______ ☐ Blood Count: ______ ☐ Chemistry Panel: ______

☐ Liver Panel: ______ ☐ EKG: ______ ☐ Cardiac Stress Test: ______

☐ Colonoscopy: ______ ☐ Functional Medicine Workup: ______ ☐ Other: ______

Imaging/X-Rays: (include Body Region and Reason for test)

X-ray: ______ CT Scan: ______

MRI: ______ Ultrasound: ______

Bone Density: ______ Other Imaging: ______

*******Please provide your doctor with all relevant imaging reports and lab results with dates*******

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. Note that we are NOT primary care providers, but need to be up to date on your health in order to adequately care for you. I also authorize the healthcare providers to perform the necessary health care services I may need, including Osteopathic Manipulation.

Due to the interrelated function of the musculoskeletal system and all connective tissues, Osteopathic treatment often includes parts of the body remote from the site of pain or injury. If you have any questions or concerns before or during the treatment, including discomfort, please ask right away so that your doctor can explain the procedure and adapt the techniques to your specific needs.

☐ I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THE ABOVE PARAGRAPH AND CONSENT TO OSTEOPATHIC TREATMENT.

Signature: ______ Date: ______

For any answers requiring more space, please fill in below:

Please mark any areas of pain or concern with an X and circle any areas of numbness or tingling.