SEASIDE OSTEOPATHY

General Information

Patients Name:_____Date:_____

Date of Birth:_____Age:_____Gender: M F

Social Security #_____-_____-_____

Parent/Guardian's Name:_____

Home Address:_____Apt #:_____

City:_____State:_____Zip:_____

Home Phone #:_____Cell Phone #:_____

Work Phone #:_____Fax #:_____

Ok to leave message at: ( )Home ( )Work ( )Cell

Email Address:_____

Emergency contact

Name:_____Relationship to you:_____

Address:_____Apt #:_____

City:_____State:_____Zip:_____

Home Phone #:_____Cell Phone #:_____

Primary Care Physician

Name:_____

Address:_____Suite #:_____

City:_____State:_____Zip:_____

Phone #:_____Fax #:_____

How did you hear about us?_____

Have you ever received an Osteopathic treatment before? _____

2900 Bristol Street- Suite C-101, Costa Mesa, CA 92626
Phone 949-478-0657 Fax 714-486-3753

SEASIDE OSTEOPATHY

Medical History

What brings you into the office and when did your symptoms begin? _____

_____

_____

_____

_____

Below please list your current medical problems in order of **priority to you**

Medical Issue	What makes it Better?	What makes it worse?

Have you had any test done for your current medical problems? If yes, please note test performed, dates and results. Please bring a copy of the medical report.

Test performed	Date	Results

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Medical History Continued

Do you have a history of injuries or accidents? If yes, please include dates and type of accident below.
(Car accident, fall, head trauma, etc.)

Date	Accident and any injuries that occurred

Have you ever been hospitalized? If yes, please note dates and reason for hospitalization.

Date	Reason for Hospitalization

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Medical History Continued

Please mark all that apply and circle ongoing problems

- ☐ Arrhythmia(abnormal heart rhythm)
- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety
- ☐ Birth Defects
- ☐ Breast Problems
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Chronic Pain
- ☐ Crohn's Disease
- ☐ Drug Dependence
- ☐ Depression
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Epilepsy/Seizures
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Other Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Infertility
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Loss of Libido
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Mood swings
- ☐ Pacemaker
- ☐ Joint Replacement
- ☐ Pneumonia
- ☐ Skin Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Vertigo

Other _____

Have you ever fractured a bone? Y N

If yes which one and when:_____

Have you been told you have Scoliosis? Y N

For women only

Is your menstrual cycle regular?_____ Date of last menstrual cycle_____

Are your periods heavy? Y N Irregular? Y N Painful? Y N

Do you get PMS? Y N

Do you use contraception? Y N If yes, what kind?_____

Are you currently pregnant? Y N

Have you ever been pregnant? Y N If yes, how many times?_____

Number of live births_____ Vaginal or C-Section?_____

Number of miscarriages_____ Number of abortions_____

Did you nurse? Y N If yes, for how long?_____

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Dental History

Tooth extractions? Y N Orthodontia? Y N Root Canals? Y N

Dentures? Y N Dental Surgery? Y N Night Guard? Y N

Implants? Y N Mercury Filings? Y N

Birth History

Pregnancy Complications?_____

Were you born by a vaginal delivery or C-Section?_____

Were you born prematurely? Y N If yes how many weeks?_____

Have you been told if you had any complications at birth?_____

How were you fed? Breast Bottle

Medications that you are currently taking

Medication	Dose and Frequency	Reason for starting	Date started

Supplements (vitamins, homeopathic remedies and herbs) that you are currently taking

Supplement	Dose and Frequency	Reason for starting	Date started

Do you have any allergies? Y N

If yes please list what you are allergic to and what your reaction is._____

_____

_____

_____

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Family Medical History

Please list the age (current or when deceased) and medical history of your family members. Please include psychiatric illnesses, sensitivities/allergies and addictions.

Mother	
Father	
Siblings	
Children	
Grandmothers	
Grandfathers	

Social History

What is your typical breakfast?_____

Lunch?_____

Dinner?_____

Snacks?_____

How many 8 ounce glasses of water do you drink in a day?_____

Do you drink anything caffeinated (coffee, tea, soda)? Y N

If yes, what do you and not the frequency._____

_____

Do you drink alcohol? Y N If YES, how many drinks per week? _____

Do you smoke? Y N If YES, how much per week? _____

Do you exercise? Y N If YES, what do you do and how frequently? _____

How many hours a night do you sleep?_____

What is your typical bedtime?_____What time do you typically wake up?_____

Do you have any problem sleeping(falling asleep, night time waking, nightmares, etc)? Y N

If yes, please describe_____

_____

Who do you live with? (Please include everyone that lives in your home as well as pets)_____

_____

_____

Is there anything else you'd like me to know?

_____

_____

_____

_____

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