OSTEOPATHIC WELLNESS CENTER, 158 DANBURY ROAD, RIDGEFIELD, CT 06877 203-438-9915

INTAKE FORM -- ADULT MEDICAL AND HEALTH HISTORY

A. Identification

Name:____ **Age:**________ **Birthdate:**____/____/______ **Sex:** M / F
Address:____________________________________ **City:**___________________ **State:**______________ **Zip:**_______
Phone: (H)_______________________ **(C)**_______________________ **(W)**________________________
Email: ___________________________________ **How did you hear about us?**__________________________________
Primary Care Physician & Address:____
Emergency Contact & Phone:____
Insurance Company and ID#:____
(although we are out of network, we will provide you with an insurance receipt that you can submit to your insurance company for out-of-network benefits, if any)
Policy Holder's Name and Date of Birth:____

B. Chief Complaint

Please list your major problems and/or symptoms and the approximate dates they began (if none, please write your reason for seeking this consultation).

Problem and/or Symptom	Date Problem Began

If you have seen other practitioners for these problems, indicate the results of these evaluations:

____

____

Is your medical condition the result of a work-related injury: YES NO
Is your medical condition the result of an automobile accident or personal injury claim: YES NO
Please tell us more about your pain: When did it begin____________ **Was the onset:** sudden / gradual

Location of Pain	Describe (sharp, dull, shooting, throbbing, aching…)
i.e. Right side of low back	**Intermittent; sharp and shooting**

Is your pain worse (check the box that best applies):

	At night		In the morning		End of shift/day		Hot, humid days
	No difference day or night		Wet/cloudy days		Cold days		Certain time of year

Please circle the number on the line below that describes the **overall AMOUNT of pain you are experiencing TODAY**:
No pain--**worst pain imaginable**
0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the **WORST your pain has been in the LAST MONTH**:
No pain--**worst pain imaginable**
0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the **LEAST your pain has been in the LAST MONTH**:
No pain--**worst pain imaginable**
0 1 2 3 4 5 6 7 8 9 10

C. **Family Medical History:** Please indicate if you or your family have had any of the following problems in the past.

Condition		Condition		Condition		Condition		Condition	
Alcoholism		**Depression**		**Herpes**		**Lyme Disease**		**Smoker**	
Allergies		**Diabetes**		**HIV**		**Mental Illness**		**Thyroid Disease**	
Anemia		**Digestive Disease**		**Hypoglycemia**		**Migraine Headache**			
Arthritis		**Drug Problems**		**Hepatitis**		**Multiple Sclerosis**			
Asthma		**Eating Disorder**		**High Blood Pressure**		**Prostate Disease**			
Cancer		**Eczema**		**Irritable Bowel**		**Rheumatic Fever**			
Celiac Disease		**Emphysema**		**Kidney Disease**		**Seizures**			
Crohn's Disease		**Heart Disease**		**Lupus/AutoImmune**		**Stomach/Intestinal Ulcers**			

D. Hospitalization / Surgical History

DATE	REASON

E. **Trauma History:** Please write your age and type of trauma you have experienced, including falls, motor vehicle accidents and emotional trauma.

F. **Current Medications / Supplements:** Please write name, dosage and how often taken.

Prescription / Over the Counter Medications	Supplements

G. **Allergies: Are you allergic to any medications/substances:** ___No ___Yes (list and explain reaction)

____

____

H. Social History please circle your answers

Do you smoke or chew tobacco: No Yes, _____ packs per day for _____ years

Did you ever smoke or chew tobacco: No Yes, when did you quit?______________________

Alcohol intake: Never Occasional, average number of drinks per day_______

Do you currently, or have you ever used recreational drugs ___No ___ Yes

Occupation (current or previous):____

Are you working: Full-time Part-time Retired Disabled

Are you: Single Married Divorced Widowed

Do you have any children: If yes, what are their ages?____

I. Review of Systems: Please check next to the symptoms that you have experienced over the past 6 months.

General		Skin		Eyes		Ears		Nose	
Fevers		Dryness		Eye Pain		Excessive Wax		Runny Nose	
Night Sweats		Rashes		Redness		Discharge		Nasal Discharge	
Insomnia		Itching		Discharge		Itching		Sneezing	
Frequent Colds/Flu		Nail Fungus		Itching		Ringing / Tinnitus		Frequent Bleeding	
Fatigue		Brittle Nails		Excessive Tearing		Decreased Hearing		Frequent Snoring	
				Dryness					
				Blurred Vision					
Mouth		**Throat**		**Endocrine**		**Cardio/Pulmonary**		**Gastrointestinal**	
Oral Sores		Frequent Soreness		Intolerance to Heat		Shortness of Breath		Heartburn	
Funny Taste		Difficulty Swallowing		Intolerance to Cold		Palpitations		Bloating/Gas	
Bad Breath		Painful Swallowing		Shakiness		Cough		Nausea	
Coating on Tongue		Change in Voice		Fatigue		Chest Pain		Vomiting	
		Frequent Clearing Throat		Increased Appetite		Leg Cramps when Walking		Hemorrhoids	
		Hoarseness		Decreased Appetite		Leg Cramps at Night		Black or Dark Stools	
				Weight Gain/Loss		Varicose Veins		Blood in Stools	
				Sweat Easily		Lightheadedness		Constipation	
				Cold Hands/Feet		Passed Out		Diarrhea	
				Hair Loss/Thinning		Leg Swelling		Thin Stools	
Neurological		**Mental/Emotional**		**Musculoskeletal**		**Genitourinary**		**Men Only**	
Numbness of a Limb		Anxiety		Joint Pain		Difficulty Urinating		Testicular Lumps	
Weakness of a Limb		Depression		Muscle Aches		Cloudy Urine		Penile Discharge	
Tension Headaches		Suicidal Thoughts		Back Pain		Involuntary Loss of Urine		Penile Lesions	
Migraine Headaches		Panic Attacks		Morning Stiffness		Frequent Urination		Impotence	
Room Spinning		Nervousness				Nighttime Urination		Breast Enlargement	
Head Trauma									
Memory Loss									
Other:									

OSTEPATHIC WELLNESS CENTER, LLC FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review this section and sign as acceptance below.

- Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to your visit to discuss.
- Cancellation Policy: I understand that there is a $75 charge for all missed or cancelled appointments with less than 24 hours notice (business day). This fee must be paid prior to scheduling another appointment.
- Minor Patients only: The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.
- There will be a $35 fee for returned checks.
- Please help us to keep our operating costs down by paying with cash or check.

I have read and understand my financial responsibilities as outlined above:

____ __ ____________________________

Patient's Signature (or person signing on behalf of patient) Date

____

Patient's Printed Name

OSTEOPATHIC WELLNESS CENTER, LLC CONSENT FORM & PRIVACY NOTICE

Please review this section and sign as acceptance below.

Consent for Treatment:

I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Medical Release Authorization:

With my consent, Osteopathic Wellness Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

Consent for Contact:

With my consent, Osteopathic Wellness Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED

Osteopathic Wellness Center is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy:

At Osteopathic Wellness Center your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure:

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

OSTEOPATHIC WELLNESS CENTER, LLC CONSENT FORM & PRIVACY NOTICE

Please review this section and sign as acceptance below.

Practice Duties – Regarding your health care information:

Osteopathic Wellness Center is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

Osteopathic Wellness Center is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights – Regarding their health care information:

The patient has the right to request the practice to restrict use and disclosure of protected health information. Osteopathic Wellness Center is not required to agree to the requested restriction.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to Osteopathic Wellness Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Osteopathic Wellness Center may decline to provide treatment to me.

____ ____________________________

Patient's Signature or person signing on behalf of patient Date

____

Patient's Printed Name

What to Expect After Treatment (this page is for you to keep):

Osteopathic treatment is unique to every individual. There are several things that will help you to better understand the process…..

1. After the initial one or two treatments, occasionally you may feel worse before you notice any relief. This is because as your self-healing mechanism is activated, your body continues to readjust as it integrates the treatment. This usually passes after several hours or may last up to a full day or so.

   For increased pain after a treatment, we recommend **Topricin cream** (topical homeopathic) applied to all painful areas 2 to 3 times daily. Please continue using this as prescribed, as it will speed up the healing of tissues, as well as provide pain relief. **Bach Rescue Remedy** is sometimes prescribed to help the treatments to integrate better for the first month. It is also good for very stressful events (physical or emotional). Take 1 dropperful under the tongue, every 1 to 2 hours. **Saloxicin** (a natural anti-inflammatory) can also be taken, 2-3 tabs 3 times daily. A 20-minute bath with **Epson salt** or sea salt will help to draw toxins out of the body and provide muscle relaxation. **Tylenol or Motrin** may be used if pain is more severe.

   Often nutritional support will also be recommended to further speed up the body's healing process. We will often recommend **Xymogen or Metagenics** other high quality nutritional supplements. It is best to take them as prescribed with meals to improve absorption.

2. You may notice significant improvement, some improvement, or none at all after the first treatment. On average, it takes about 4 to 5 treatments to begin to experience relief from the original complaints. This varies tremendously with each person based on their overall level of health, which depends on various factors (multiple medical problems, number of prescription medications, amount of exercise, quality of diet, lifestyle stressors and old injuries and surgeries.)

   Usually, you will return for follow-up in a few days or a week later. The initial treatments will usually be spaced apart by a few days or up to a week or two. As Dr. Johnston assesses your system at each visit, he will determine when it is best to return. Treatment can last from 30-45 minutes depending on what your body will accommodate for that day. As your systems begin to improve and your nervous system and cranial mechanism improves, we will begin to space out treatments by an extra week or so. After you have recovered, it is still recommended that you return in 4 to 6 weeks for a maintenance (tune up) treatment. Osteopathic treatment can prevent many problems before they surface and keep you in overall good balance, alignment and health.

3. It is helpful to refrain from chiropractic and other manual treatments during osteopathic treatment to better evaluate your response. Gentle massage, acupuncture, shiatsu, and occasionally other treatments may be done one to two days before or after osteopathic treatment. Please check with Dr. Johnston to be sure. After your treatment, it is helpful, if you can relax for 30-60 minutes to get the optimum benefit. You may feel very tired after a treatment if it is your first one or if it has been several months since your last visit. If you are exhausted, please listen to your body and go to bed early that evening.

4. Often times, after patients start to feel better, they go back to their normal activity too soon and end up overdoing it. This can cause the strain pattern to return and feel like your pain and other symptoms have returned. This is actually only a minor setback and one or two treatments will correct this. Please limit your normal activity (vigorous workouts, golf, yoga, weight training, gardening, lifting, bending over, etc.) as much as possible during the first few treatments. Please ask Dr. Johnston questions about specific activities you may do and how to modify them. Usually, you are the best judge, so please listen to your body and allow it time to rest and heal.

5. Dr. Johnston often will recommend gentle stretching and deep breathing and relaxation exercises initially and then more extensive core strengthening programs and exercises from **Dr. Fulford's book, "The Touch of Life".** It is very important to do these exercises as prescribed, as they are part of the treatment and healing process. The core muscles, when strengthened correctly, will enable you to gain a greater awareness of your body and your everyday movements, as well as to maintain better alignment and postural stability. This will lead to longer lasting effects from each osteopathic treatment and quicken recovery. **The Core Program,** by Peggy Brill, PT is a terrific book to start with, Core I, every other day for the first 4-6 weeks.

6. Remember; please ask questions if you have any. The Osteopathic Resource Sheet lists several places to find more specific details about osteopathy. **The Touch of Life, by Robert Fulford, DO** is highly recommended quick reading to explain Osteopathy. As one of my patients told me, if they had not read Dr. Fulford's book, they would not have understood the treatment I was doing! You can leave a message anytime on the machine and Dr. Johnston will return your call as soon as possible. Osteopathic treatment is unique for each individual and everyone responds to the treatment at different rates. This is because the body's healing mechanism is unique for each person.