NEBH Osteopathic Intake Form

Name:_____ Today's Date:_____
DOB:_____ Age:_____

Home
Address:_____
Best phone # to reach you:_____ Email address: _____

How did you hear about Dr. Lowney?
_____

Insurance plan: _____
Insurance #:_____
Subscriber's Name:_____
Subscriber's DOB:_____

Do you have a Primary Care Provider? Yes / No
If yes, who is your Primary Care
Provider?:_____

What other doctors or healthcare providers do you see? (i.e. cardiologist, gynecologist, therapists, acupuncturists
etc)_____
_____

Any drug allergies?_____ Any other
allergies?_____
What medications do you
take?_____
_____
_____

What medical conditions do you
have?_____
_____
_____

What surgeries have you
had?_____
_____

What medical conditions run in your family? Specifically your:
Mother: _____
Father: _____
Brothers and Sisters: _____
Your Children: _____
Any one else in the family ever have cancer or a clotting disorder?_____
_____

Are you married, single, divorced, or widowed?_____
Do you have any children?_____
Who lives in your home?_____
Are you working/going to school/unemployed/disabled or something else? Please let us know what you are doing:
_____

Do you smoke? Yes / No / Former How many packs per day?_____
How long have you been smoking?_____
Do you drink alcohol? Yes / No How many drinks per week?_____
Do you use any illicit drugs (ie marijuana, cocaine, heroine etc) Yes / No

What is the main reason/ailment/goal for your visit today with Dr. Lowney? _____

_____

In your own words, please summarize how your musculoskeletal problem began?
_____
_____
_____

Have you ever received an Osteopathic Treatment? Yes / No If yes explain: _____

_____

Please circle the types of treatments/interventions you already tried?
Physical Therapy Acupuncture Chiropractic Injections Surgery
Behavioral Therapy Nutritional Massage Reiki
Other: _____

What Medications have you tried that you are not presently taking? _____
_____

On a scale of 0-10, how determined are you to have complete resolution of this ailment or to achieve your health goal? With '0' being 'it would be nice but is not a priority' and '10' being 'I would literally do anything!': _____

How interested, on a 0-10 scale, are you in making lifestyle changes to achieve your goal? _____

What do you feel has been the biggest barrier to you achieving your goal?_____

_____

How often do you exercise and what exercise do you perform?_____

_____

How many hours of sleep do you typically get a night?_____
How many times do you wake during the night?_____

Is there anything else you would like to tell Dr. Lowney about yourself?_____
_____
_____
_____