Integrative Medicine of Pueblo
200 W B St Ste 110
Pueblo, CO - 81003

OMT Intake

First Name *

Last Name *

Date of Birth *

History of Present Illness

History of Present Illness

Background

In a few words, please describe what's bringing you in for Osteopathic Manipulative Treatment.

When did it start?

What were the conditions that occured at the time of onset?

☐ Activity change ☐ Injury ☐ Nothing ☐ Stressful life event
☐ Other

Comments

Location

Where is your area(s) of concern today?

☐ Head
- ☐ Right
- ☐ Left
- ☐ Both sides
- ☐ Back
- ☐ Forehead
- ☐ Jaw
- ☐ Other (indicate below)

☐ Neck
- ☐ Right
- ☐ Left
- ☐ Both sides

☐ Upper back
- ☐ Right
- ☐ Left
- ☐ Both sides

- ☐ Lower back
  - ☐ Right
  - ☐ Left
  - ☐ Both sides
- ☐ Sacrum & pelvis
  - ☐ Right
  - ☐ Left
  - ☐ Both sides
- ☐ Upper extremity
  - ☐ Shoulder
    - ☐ Right
    - ☐ Left
    - ☐ Both sides
  - ☐ Elbow
    - ☐ Right
    - ☐ Left
    - ☐ Both sides
  - ☐ Wrist
    - ☐ Right
    - ☐ Left
    - ☐ Both sides
  - ☐ Hand
    - ☐ Right
    - ☐ Left
    - ☐ Both sides
- ☐ Lower extremity
  - ☐ Hip
    - ☐ Right
    - ☐ Left
    - ☐ Both sides
  - ☐ Knee
    - ☐ Right
    - ☐ Left
    - ☐ Both sides
  - ☐ Ankle
    - ☐ Right
    - ☐ Left
    - ☐ Both sides

- ☐ Foot
  - ☐ Right
  - ☐ Left
  - ☐ Both sides
- ☐ Chest & ribs
  - ☐ Right
  - ☐ Left
  - ☐ Front
  - ☐ Back
  - ☐ Upper
  - ☐ Middle
  - ☐ Lower
- ☐ Other _____

Comments _____

Quality

What does it feel like?

☐ Aching ☐ Dull ☐ Numbing ☐ Sharp ☐ Shooting
☐ Throbbing ☐ Tingling
☐ Other _____

Comments _____

Severity

How severe is it?

☐ Not at all severe ☐ Mild ☐ Moderate ☐ Severe

Comments _____

Place rate your problem from 0 (does not interfere with daily activities) to 10 (severely limits daily activities).

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9-10

Trend

Is the problem getting worse or better?

☐ Improving ☐ Stable/unchanged ☐ Waxes and wanes
☐ Worsening

Comments _____

Aggravating factors

What makes it worse?

☐ Bending ☐ Change in position ☐ Coughing
☐ Deep breathing ☐ Exertion ☐ Leaning forward
☐ Lying down ☐ Nothing ☐ Sitting ☐ Standing
☐ Turning ☐ Twisting ☐ Walking
☐ Other _____

Comments _____

Alleviating factors

What makes it feel better?

☐ Acetaminophen (Tylenol) ☐ CBD ☐ Chiropractic
☐ Heat ☐ Ice ☐ Injections ☐ Leaning forward
☐ Lying down ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ NSAIDs (Ibuprofen, Advil, Aleve, etc) ☐ Opioids
☐ Osteopathic treatment ☐ Physical therapy ☐ Rest
☐ Supplements (please specify in comments)
☐ Other _____

Comments _____

Prior Evaluation

Have you seen another provider for this concern?

☐ Yes ☐ No

Comments _____

Have you had any imaging for this concern? If so, what were the results?

☐ Yes ☐ No

Comments _____

Review of Systems

Review of Systems

Please Check Positives Only

General

☐ Fever ☐ Chills ☐ Fatigue ☐ Weight gain
☐ Weight loss ☐ Excessive Sweating ☐ Weakness
☐ Night sweats
☐ Other _____

Head

☐ Head Trauma history ☐ Headache ☐ Migraine
☐ Hair loss
☐ Other _____

Ears, Nose, Mouth and Throat

☐ Hearing loss ☐ Tinnitus (ringing in the ears)
☐ Ear discharge ☐ Ear pain ☐ Excessive earwax
☐ Nasal discharge ☐ Post nasal drip
☐ Nasal or sinus congestion ☐ Sinus pain ☐ Sneezing
☐ Nose bleeds ☐ Loss of Taste ☐ Loss of Smell
☐ Gum/Dental Problems ☐ Hoarseness ☐ Sore throat
☐ Swollen neck ☐ Mouth sores
☐ Difficulty/pain on swallowing ☐ Bad Breath
☐ Jaw/TMJ Problems
☐ Other _____

Eyes

☐ Corrective lenses (glasses/contacts) ☐ Dry eyes
☐ Eye Redness ☐ Glaucoma ☐ Blurred vision
☐ Double Vision ☐ Itchy eyes ☐ Vision loss
☐ Eye Discharge ☐ Cataracts
☐ Other _____

Cardiac

☐ High blood pressure ☐ Low blood pressure
☐ Angina/Chest pain ☐ Palpitations ☐ Stroke
☐ Shortness of breath lying down ☐ Cold hands/feet
☐ Other _____

Respiratory

☐ Asthma ☐ Shortness of breath ☐ Wheezing ☐ Cough
☐ Sputum/Phlegm ☐ Coughing up blood ☐ Pain on breathing
☐ Other _____

Gastrointestinal

☐ Appetite Change ☐ Nausea ☐ Vomiting ☐ Indigestion
☐ Constipation ☐ Diarrhea ☐ Food intolerance
☐ Abdominal pain ☐ Hemorrhoids ☐ Heartburn
☐ Excessive Gas/bloating ☐ Rectal bleeding ☐ Rectal Itching
☐ Blood in stool ☐ Black Tarry stool
☐ Other _____

Urinary

☐ Frequent urination ☐ Incontinence ☐ Kidney stone history
☐ Blood in urine ☐ Pain with urination ☐ Waking to urinate
☐ Urinary urgency ☐ Flank pain ☐ Frequent urinary infections
☐ Other _____

Musculoskeletal

☐ Muscle aches ☐ Muscle spasms ☐ Muscle weakness
☐ Joint stiffness ☐ Joint pain ☐ Neck pain ☐ Back pain
☐ Other _____

Skin/Hair

☐ Acne ☐ Hives ☐ Eczema ☐ Dry skin ☐ Itchy skin
☐ Rash ☐ Rosacea ☐ Warts ☐ Skin color changes
☐ Hair loss ☐ Hair Thinning ☐ Dandruff ☐ Nail changes
☐ Other _____

Neurological

☐ Loss of sensation/Numbness ☐ Tingling ☐ Tremors
☐ Weakness ☐ Fainting ☐ Dizziness ☐ Seizures
☐ Loss of memory ☐ Brain fog ☐ Paralysis
☐ Other _____

Mental/Emotional

☐ Anger/irritability ☐ Fear/panic ☐ Anxiety
☐ Tension/stress ☐ Depression ☐ Suicidal thoughts
☐ Substance abuse ☐ Insomnia or difficulty sleeping
☐ Mood swings
☐ Other _____

Endocrine

☐ Heat Intolerance ☐ Cold Intolerance ☐ Thyroid Problems
☐ Excessive Thirst ☐ Excessive Hunger
☐ Other _____

Hematological/Immune/Lymphatic

☐ Easy Bleeding/Bruising ☐ Allergies ☐ Frequent Infections
☐ Swollen Glands ☐ Breast Pain/Tenderness ☐ Breast Lumps
☐ Nipple Discharge
☐ Other _____

Female Reproductive

☐ Irregular Cycles ☐ Bleeding or Spotting in between Menses
☐ Excessive Bleeding ☐ Pain during Intercourse
☐ PMS Symptoms (emotional and/or physical symptoms around the time of menses)
☐ Vaginal Itching or Dryness ☐ Vaginal Discharge
☐ Sexual Difficulties
☐ Other _____

Male Reproductive

☐ Hernia ☐ Testicular Mass ☐ Testicular Pain
☐ Sexual Difficulties
☐ Penile Symptoms (specify in the "others" section below)
☐ Waking at night to urinate ☐ Change in urine stream/flow
☐ Other _____

Lifestyle Review

Past Medical History

Nutrition

How would you describe your diet?

☐ Poor ☐ Fair ☐ Good ☐ Excellent
☐ Other _____

Comments _____

Do you follow any particular dietary pattern? (Mediterranean, Paleo, Keto, Weight Watchers, etc)

How many servings a fruits and vegetables do you get per day on average?

☐ Less than 1 ☐ 1-2 ☐ 3-4 ☐ 5 or more

How many times do you eat out per week?

☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 4-5 ☐ 6+

Comments _____

Besides water, what fluids do you drink on a regular (weekly) basis? Please describe the amounts in comments.

☐ Alcohol ☐ Coffee ☐ Energy drinks ☐ Soda
☐ Sweet Tea ☐ Unsweetened Tea
☐ Other _____

Comments _____

Movement

How would you describe your lifestyle in terms of movement?

☐ Sedentary (I am sitting most of the day)
☐ Moderate (I sit, stand and walk fairly equally throughout the day)
☐ Active (I am on my feet most of the day)
☐ Other _____

Comments _____

How much exercise do you get in an average week?

☐ 0 hours ☐ 1-2 hours ☐ 3-4 hours ☐ 4-5 hours
☐ >6 hours
☐ Other _____

Comments _____

What types of physical activity do you perform?

☐ None ☐ Aerobics ☐ Biking ☐ Dancing
☐ Gardening ☐ Hiking ☐ HIIT ☐ Pilates ☐ Running
☐ Swimming/Aquatics ☐ Yoga ☐ Walking ☐ Weight lifting
☐ Other _____

Comments _____

Sleep

How many hours of sleep do you get each night on average?

☐ Less than 4 ☐ 4-5 ☐ 5-6 ☐ 6-7 ☐ 7-8
☐ More than 8

Comments _____

How would you rate your sleep quality?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Comments _____

Do you take any medications or supplements to help you sleep at night? If yes, what do you take?

☐ Yes ☐ No

Comments _____

Do you suffer from any medical conditions that negatively affect your sleep?

☐ None ☐ Anxiety ☐ Depression
☐ Prostate problems, frequent urination ☐ Restless leg syndrome
☐ Sleep apnea
☐ Other _____

Comments _____