William James Brooks, DO

Board Certified - Osteopathic Manipulative Medicine

Please review the entire form prior to answering. Thank you!

NAME _____ DATE OF BIRTH _____

ADDRESS _____

City _____ State _____ Zip _____

PHONE (H) _____ (W) _____

(C) _____ REFERRED BY _____

MARITAL STATUS: M S W D VET STATUS: N Y Combat?

EDUCATION (Degree or last grade completed) _____

SPOUSE & CHILDREN ***or*** PARENTS & SIBLINGS: Name, Age, Gender, Health Status

_____

_____

_____

_____

OCCUPATIONAL HISTORY _____

DISABLED: N Y Since? _____ Why? _____

Income Source(s) _____ Sufficient for needs? _____

Handed: Right Left Both If both, describe. _____

HEALTH MAINTENANCE

CURRENT EXERCISE PROGRAM _____

_____

_____

PRIMARY CARE PHYSICIAN _____

Year of last physical exam _____ rectal exam _____ Men: genital exam _____

Women: pap & pelvic exam _____ breast exam _____

HABITS Never? How much? For how long? Quit date?

Caffeine _____ Tobacco _____

Alcohol _____ Street Drugs _____

OFFICE 5281 N Via Sempreverde, Tucson, AZ 85750
PHONE (816) 746-0128
FAX (877) 794-8283
WEB SITE www.wjbrooksdo.com

Name_____Date of Birth_____

HEALTH COMPLAINTS

Please list by letter (A through . . .) and describe in detail the health complaint(s) for which you are seeking care: _____

CHRONOLOGY / CAUSATION

When did the *present complaints* begin? What caused them? Sudden or gradual onset? Have they improved, worsened, or remain unchanged?_____

If this episode is ***not*** *the first time in your life* that you have experienced *this or similar* complaints, when was? Sudden or gradual onset? Describe in detail what initially caused the complaints and whether they resolved, partially improved, or persisted.

Are your ***current*** complaints constant or intermittent? If intermittent, for how long do they last, and how frequently do they occur?_____

Is there a time of day / week / month/year when they are typically better / worse?

If you have an attorney helping you with a personal injury or workman's compensation claim, please indicate their name & phone #._____

Name_____Date of Birth_____

IMPACT

As a result of your complaints have you been unable to work or had to change jobs / attend school? Is your job still available to you? _____

As a result of your complaints have you been unable to engage or been limited in self-care, household chores, sexual relations, social / leisure / athletic activities? Describe.

Describe how *therapeutic exercise* has altered your symptoms?_____

Have you ever experienced *joint manipulation or "adjustments"* - from whom, when, why, results? _____

Describe in detail any activities, postures, reflexes, treatments that make your conditions ***worse***. How long can you maintain activity or posture before they become problematic? _____

Describe in detail any activities, postures, reflexes, treatments that make your conditions ***better***._____

Name_____Date of Birth_____

CONCURRENT or RECENT SYMPTOMS

Explain. Note the cause, if known.

Sleep: trouble falling & / or staying asleep?_____

_____

Mood / Energy_____

Thinking / Memory_____

Dizziness / Faintness_____

Eyes / Visual_____

Ears / Hearing_____

Nasal / Sinus / Smell_____

Mouth / Dental / Taste_____

Throat / Swallowing / Speech_____

Lungs / Breathing_____

Heart / Circulation_____

Abdomen / Rectum / Digestion / Elimination_____

_____

Breasts / Genitalia / Menstruation / Erection-Ejaculation / Urination_____

_____

Extreme hunger / thirst; intolerance of heat / cold_____

Weight gain / loss Amount? Cause?_____

Skin / Hair / Other_____

_____

Name_____ Date of Birth_____

INVESTIGATIONS

List the physicians / dentists / therapists with whom you have consulted regarding your complaint(s)._____

_____

_____

Please indicate what region and the results of any of the following performed to investigate your symptoms:

"X-rays"_____

_____

MRI scan_____

CT scan_____

Bone scan_____

Arthrogram_____

Myelogram_____

Discogram_____

Bone density scan_____

EMG (electromyogram)_____

EEG (electroencephalogram)_____

Neuropsychiatric evaluation_____

Other_____

CURRENT MEDICATIONS

Include birth control pills, non-prescription medicine, & nutritional supplements. List name, amount, and timing. _____

_____

_____

_____

_____

_____

_____

ALLERGIES and INTOLERANCES to MEDICATIONS

_____

_____

Name_____Date of Birth_____

FAMILY HISTORY

Do any diseases tend to “run in your family”? _____

_____

Do other members of your family have significant complaints similar to yours?

_____

_____

Has there been any incidence of physical, sexual, and/or substance (drugs, alcohol, nicotine, caffeine, food) abuse in your family?_____

_____

_____

LIFETIME TRAUMA HISTORY

Please list ALL **motor vehicle accidents**: when, driver or passenger, nature of collision, wearing seatbelt/shoulder harness, headrest properly positioned, did any part of your body impact the car, onset of symptoms, diagnosis, treatment, resolution of symptoms? List ALL **work injuries**: when, nature of injury, onset of symptoms, diagnosis, treatment, resolution of symptoms? List ALL **major falls**: onto which area(s) of your body and what symptoms resulted. List ALL **fractures** (include nose, fingers, toes): when & how they occurred. List ALL **sprains/strains**: when & how they occurred. List ALL **alterations of consciousness** (“knocked out”, “dazed”, “bell rung”) from physical forces: which year & cause. Have you had "the **wind knocked out of you**"? Describe which year & cause. Did or do you participate in **contact sports**? For children, describe **mother’s pregnancy / labor / delivery.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name_____ Date of Birth_____

SURGICAL & ILLNESS HISTORY *When? Why?*

Eyes / Ears_____

_____

Nose / Sinus / Mouth / Throat_____

_____

Dental: Wisdoms extracted — When? Why?_____

Braces — When?_____ Dentures?_____

Bridges?_____ Other?_____

Lungs / Heart / Circulation_____

_____

Abdomen / Rectum_____

_____

Pelvis / Genitalia_____

_____

# of Pregnancies_____ Births_____ C-sections_____

Episiotomies_____ Miscarriages_____ Abortions_____

Neurological_____

_____

Psychological_____

_____

Musculoskeletal (other than trauma related)_____

_____

Skin / Hair_____

_____

Glandular / Other_____

_____

Patient's Signature_____ **Date**_____

Physician's Signature_____ **Date**_____