William James Brooks, DO

Board Certified - Osteopathic Manipulative Medicine

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

NAME _____ DATE OF BIRTH _____

ADDRESS _____

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 DOCTOR _____

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 _____

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Name_____Date of Birth_____

HEALTH COMPLAINTS

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

_____

_____

_____

_____

_____

CHRONOLOGY / CAUSATION

When did the *present complaint(s)* begin? What caused it (them)? Sudden or gradual onset? Has it (have they) improved, worsened, or remain unchanged?_____

_____

_____

_____

Is (are) your current complaint(s) constant or intermittent? If intermittent, for how long does it (do they) last and how frequently does it (do they) occur?_____

_____

_____

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

_____

_____

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

_____

_____

_____

_____

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 complaint(s) 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 complaint(s) 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 condition(s) ***worse***. How long can you maintain activity or posture before it (they) become(s) problematic? _____

Describe in detail any activities, postures, reflexes, treatments that make your condition(s) ***better***._____

Name_____Date of Birth_____

CONCURRENT or RECENT SYMPTOMS Explain; noting the cause.

Sleep: do you have trouble falling asleep? Staying sleep?_____

Mood/Energy_____

Thinking/Memory/Dizziness/Faintness_____

Eyes/Visual _____

Ears/Hearing_____

Nasal/Sinus/Smell_____

Mouth/Dental/Taste/Throat/Swallowing/Speech_____

Lungs/Respiration_____

Abdomen/Digestion/Rectum/Elimination_____

Heart/Circulation_____

Genitalia/Urination /Breasts/Menstruation/Sexual function_____

Extreme hunger/thirst or intolerance of heat/cold_____

Weight gain/loss – explain_____

Skin/Hair/Other_____

Name_____ Date of Birth_____

INVESTIGATIONS

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

_____

_____

If any of the following have been performed to investigate your complaint(s), indicate what region and results:

"X-rays"_____

_____

CT scan_____

MRI scan_____

Bone density scan_____

Bone scan_____

Arthrogram_____

Myelogram_____

Discogram_____

EMG (electromyogram)_____

EEG (electroencephalogram)_____

Neuropsych 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.**

_____

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_____

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_____ Miscarrages_____ Abortions_____

Neurological_____

_____

Psychological_____

_____

Musculoskeletal (other than trauma related)_____

_____

Skin/Hair_____

_____

Glandular/Other_____

_____

Patient's Signature_____ **Date**_____

Physician's Signature_____ **Date**_____