PATIENT INFORMATION & HISTORY

NAME: _____ BIRTH DATE: _____ AGE: _____
Last First MI

Please fill out the form COMPLETELY.
If you do not know an answer to a question, please write '**Unknown**.'
If a question does not apply to you, please write, '**N/A**.'

YOUR WRITTEN DETAILED DESCRIPTION

Are you seeing Dr. Cohn because of PAIN? ☐ Yes ☐ No

IF NO: Reason(s) you are requesting to be seen by Dr. Cohn:

_____
_____
_____
_____

IF YES:

Date symptoms **first appeared:** _____

CURRENT PAIN LOCATION: Please, describe your pain including its location, if 'shooting' pain is present, please describe where it starts and where it travels to:

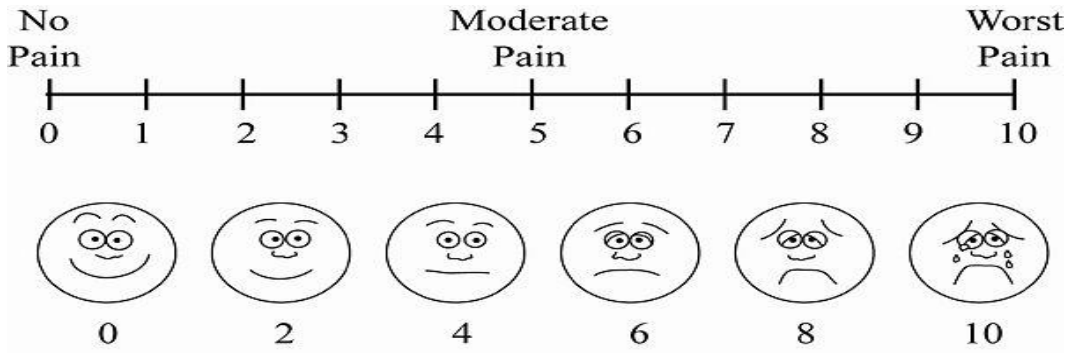
_____
_____
_____
_____
_____

Type(s) of pain you are experiencing (check all that apply):

☐ Aching ☐ Numbing pain ☐ Pins and Needles ☐ Burning
☐ Sharp or Stabbing ☐ Throbbing ☐ Other (describe)_____

Are your joints HYPERFLEXIBLE? ☐ Yes ☐ No

Use the pain scale, below, to answer the next 3 questions:



a. **Least** pain you EVER experience: ____
b. **Worst** Pain level you EVER experience: ____
c. **Average** daily pain level: ____

What causes your symptoms to worsen?

☐ Unknown
☐ Nothing

☐ Medicines _____
☐ Stretching _____
☐ Exercising _____
☐ Lying Down _____
☐ Sitting _____
☐ Other (describe) _____

What causes your symptoms to improve?

☐ Unknown
☐ Nothing

☐ Medicines _____
☐ Stretching _____
☐ Exercising _____
☐ Lying Down _____
☐ Sitting _____
☐ Other (describe) _____

What have you done or tried to resolve this problem (nerve blocks, epidurals, steroid injections, prolotherapy, yoga, physical therapy, chiropractic, pain medications, etc.)? _____
_____

Do you have a home therapeutic exercise program that you do on a regular basis? ☐ Yes ☐ No

MEDICATIONS

Please list each drug you take (include nonprescription drugs such as aspirin and medical marijuana), it's amount and how often you currently are taking it:

	Name of Medicine	**Dose (amount)**	**How often**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Are you allergic to any medications? ___Yes ___No

Please list any medications you are allergic to and the REACTION you had to them:

_____

_____

_____

SOCIAL HISTORY

Marital Status (circle one): (Single / Married / Widowed / Divorced / In a stable relationship)

Current Occupation: _____

☐ Current Smoker or Tobacco User
Packs per day:_____

☐ Drink Alcoholic Beverages
Amount per day/week/month or year: _____

Does your condition affect your ability to **fall asleep** or **stay asleep** or the **quality of your sleep**? ☐ Yes ☐ No
If yes, please describe:

_____
_____

TRAUMA HISTORY

List any car accidents or bad falls (work injuries, sports injuries, childhood injuries, etc.) not already mentioned:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Operations: list and indicate approximate year (Include C-sections):

_____
_____
_____

READ CAREFULLY:
Please circle "Y" or "O" for each symptom you have. If you do not have a symptom, do not mark anything.

	Yes	Occasional
Itchy skin	Y	O
Rashes	Y	O
Boils	Y	O
Headaches	Y	O
Poor vision	Y	O
Pain in the eyes	Y	O
Inflammation of the eyes	Y	O
Hard of hearing	Y	O
Dizziness	Y	O
Lightheadedness	Y	O
Noises any ears	Y	O
Pain in the ears	Y	O
Nosebleeds	Y	O
Discharge from ears	Y	O
Poor teeth	Y	O
Sore tongue	Y	O
Hoarseness	Y	O
Change in voice	Y	O
Lump in throat	Y	O
Difficulty swallowing	Y	O
Chronic cough	Y	O
Coughing up blood	Y	O

	Yes	Occasional
Painful urination	Y	O
Difficulty starting or stopping urinating	Y	O
Frequent urination	Y	O
Urination at night	Y	O
Bloody urine	Y	O
Discolored urine	Y	O
Sugar, pus or albumin in the urine	Y	O
Swelling of joints	Y	O
Weakness of muscles	Y	O
Cramps in legs	Y	O
Pain in joints	Y	O
Backaches	Y	O
Varicose veins	Y	O
Stiffness of joints	Y	O
Fever	Y	O
Chills	Y	O
Sweats at night	Y	O
Intolerance to heat	Y	O
Intolerance to cold	Y	O
Fainting spells	Y	O
Convulsions or fits	Y	O

Coughing up phlegm	Y	O
Shortness of breath	Y	O
Chest pain	Y	O
Swelling of ankles	Y	O
Thumping of heart	Y	O
Tightness in the chest	Y	O
Poor appetite	Y	O
Weight gain	Y	O
Weight loss	Y	O
Pain in stomach/abdomen	Y	O
Nausea or vomiting	Y	O
Vomiting blood	Y	O
Certain foods cause Indigestion	Y	O
Constipation	Y	O
Diarrhea	Y	O
Tarry lack bowel movements	Y	O
Blood in bowel movements	Y	O
Painful or difficult bowel movements	Y	O
Piles or hemorrhoids	Y	O
Abdominal gas	Y	O

Paralysis	Y	O
Trouble sleeping	Y	O
Excessive tiredness	Y	O
Nervousness	Y	O
Sad or "blue" spells	Y	O
Difficulty with memory	Y	O
Numbness or tingling	Y	O

WOMEN ONLY:

Date of last menstrual period	_____	
Number of pregnancies	_____	
Hot flashes	Y	O
Pain before or with periods	Y	O
Discharge from vagina	Y	O
Pain or bleeding on intercourse	Y	O

Mark any of the following diseases that you have had:

☐ Scarlet fever	☐ Asthma	☐ Headaches	☐ Diabetes
☐ Rheumatic fever	☐ Pneumonia	☐ Migraine	☐ Alcoholism
☐ Hepatitis	☐ Bronchitis	☐ Sinus trouble	☐ Cancer - Type_____
☐ Chickenpox	☐ Emphysema	☐ Heart attack	
☐ Tuberculosis	☐ Arthritis	☐ Other heart disease	
☐ Herpes	☐ Gout	☐ High blood pressure	
☐ Syphilis	☐ Depression	☐ Kidney infection	
☐ Gonorrhea	☐ Hypothyroidism	☐ Frequent kidney or bladder infections	
☐ Other sexually transmitted disease	☐ Hyperthyroidism	☐ Gallbladder disease	

FAMILY HISTORY

Have any of your blood relatives had any of the following?		If so, who?
Migraines	Yes / No	_____
Arthritis	Yes / No	_____
Fibromyalgia	Yes / No	_____
Gout	Yes / No	_____
Thyroid trouble	Yes / No	_____
Depression	Yes / No	_____
Anxiety	Yes / No	_____
Hypermobility of joints	Yes / No	_____

---------- **Do Not Write On Next Page** ----------

System/ Body Area	Musculoskeletal Examination Date: _____
***Constitutional** EV EV	☐ Vitals: Pulse: _____ Resp: _____ BP (seated): _____ Wt: _____ lbs. ☐ Appearance: WNWDM-NAD___ WNWDF-NAD___ Other: _____
***Neurological/ Psychiatric** EV EV EV	☐ Mood/Affect: __Appropriate for situation __Cheerful __Depressed __Anxious __Other_____ ☐ No gross neurological abnormalities Other:_____ ☐ A&Ox3 Other:_____ ☐ Sensation: Full to light touch Other:_____ ☐ Coordination WNL _____ ☐Strength 5/5 x 4 Other: _____ ☐ DTR's +2/4 x 4 Other: _____
***Skin & Subcutaneous Tissue (4=Comp)**	Skin intact/without lesion over: ☐ Head ☐ Trunk ☐ Right UE ☐ Left UE ☐ Right LE ☐ Left LE ***OR*** LE Varicosities: ☐Left /☐Right ☐Edema ☐ Other/ Location: _____
Lymphatic	☐ No Lymphadenopathy ☐ Pos. Lymphadenopathy: Location: _____
Cardiovascular	☐ No JVD ☐ Pos. JVD ☐ Brisk capillary refill ☐ Delayed capillary refill ☐ Peripheral pulses +2/4 ☐ Other: _____
***Musculoskeletal** EV Value: 24 boxes EV	☐ Gait: __ No gross abnormalities Other: _____ ☐ Station/Posture: A/P CURVES: __ WNL C-Lordosis: __Flattened __Increased; T-Kyphosis: __Flattened __Increased; L-Lordosis: __Flattened __Increased; __Flat Feet L / R; __Head Forward

JOINTS, BONES, MUSCLES, & TENDONS

Inspection/Palpation = WNL unless otherwise noted. Muscle Strength/Tone: Neck, Spine, Ribs, Pelvis, RUE, LUE, RLE, LLE are all inspected and palpated at each visit unless otherwise specified. Abnormal muscle tension is noted on diagram (muscles drawn in are tight/restricted). L=Left R=Right B=Bilateral

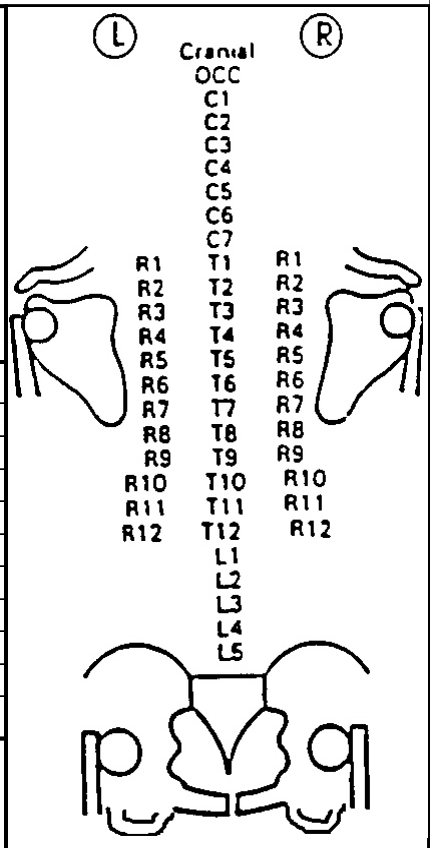
CRANIUM: __WNL Rate: ___↑ ___↓ Amplitude: ___↑ ___↓
Vitality/Energy: ___↓ Rhythm: ___ Irreg
Restrictions: Quadrant: ____ LA ____ RA ____LP ____RP
Suture: ___Sag ___Coronal __L-TP __R-TP __L-PJ __R-PJ __L-NM __R-NM
__L-ZT __R-ZT __L-NF __R-NF Other: _____

ROM restrictions: ___Sterno-Manubrial ___Costo-Sternal
LUE: __SC __AC _____
RUE: __SC __AC _____
RLE: __Ext. Rot __ Quads __Hams __IP __ITB Foot:_____
LLE: __Ext. Rot __ Quads __Hams __IP __ITB Foot:_____

T	A	R	ti/te		1	2	3	I	U	W
				Cranial						
				Cervical						
				Lt Upper Extremity						
				Rt Upper Extremity						
				Rib Cage						
				Abdomen						
				Thoracic Region, TI						
				Lumbar Region						
				Sacral Region						
				Pelvis/Hip						
				Lt Lower Extremity						
				R Lower Extremity						

T=texture abnormal A=Asymmetric R=Restriction ti=ticklish te=tender
Severity: 1-Minor 2-TART obvious 3-Symptomatic or Key lesion
Response to treatment: **I**=Improved **U**=Unchanged **W**=Worse

	L	R
St. flex. test: PSIS	___	___
L5	___	___
L4	___	___
Other _____	___	___
_____	___	___
Stork Test:	___	___
Proprioception:	___	___
Standing short leg:	___	___ ___"
ASIS:	___	___
Spring Test:	+	-



Additional Findings: _____

☐Level **3**: =/> 6 boxes
☐Level **4**: =/> 12 boxes
☐Level **5**: Every box in each section marked with an "*" and at least 1 box in each unmarked

Assessment:
1. Somatic Dysf: __Cranial __Cervical __ __UE (L/R) __Ribs __Abdomen __ Thoracic __Lumbar __Sacral __Pelvis __ __LE (L/R)
2. _____
3. _____
4. _____
5. _____
6. _____

Plan:
1. OMT performed: 1-2 Areas:__ 3-4:__ 5-6: __ 7-8: __ 9-10: __
Tx: HVLA__ ME__ Cranial__ MFR__ Fnctl__ Artic__ CST__ CMRR__ Recoil__ Still__
2. ___Warned of possible stiffness/soreness post-tx. Advised re: use of ice/heat & analgesics
3. Exercises given/reviewed: _____
4. _____
5. _____
6. ☐Recheck ____ Days ____ Weeks ____ Months ___ PRN; or prn sooner.
7. Call if problems/questions.

Signature: _____