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WWW.CASA-NATAL COM

NEW PATIENT INTAKE

Full Name: _____ Date: _____ DOB: _____

Address: _____

Phone number: _____ Email: _____

Marital Status: __ Single __ Married __ Widowed Name of Spouse/Partner: _____

Emergency contact, relation and phone #: _____

Whom may we thank for referring you? _____

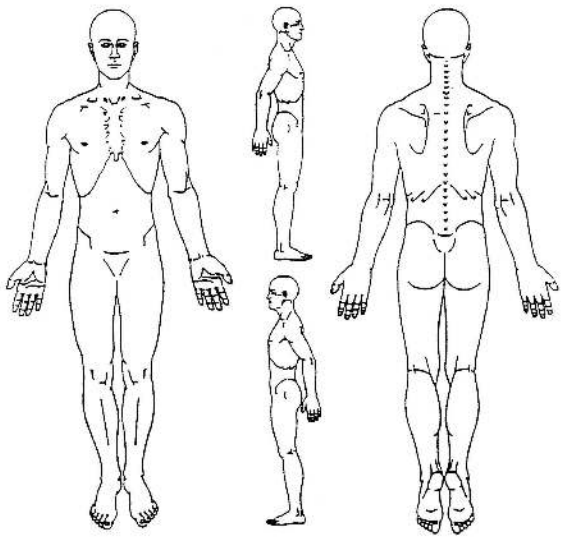
What is the reason for your visit today? _____

When and how did your problem begin? _____

_____

Have you had this problem in the past? _____

Please mark the location of your symptoms



Describe your symptoms:

__ Ache __ Sharp __ Sore __ Tight/Stiff
__ Numb/Tingling
__ Other: _____

Severity (0-10, 10=most severe pain):

Today: ___/10 At worst: ___/10 At best: ___/10

Are your symptoms:

__ improving __ getting worse
__ staying the same

How often are your symptoms:

_____ x per hour/day/week/month

What makes the problem worse? __ Sit __ Stand __ Walk __ Exercise __ Other: _____

What makes the problem better? __ Ice __ Heat __ Rest __ Massage __ Other: _____

Who have you seen for this problem? __ Massage __ Acupuncture __ MD __ PT __ Other: _____

Other complaints you would like us to address? _____

_____

Review of Systems: Please check any conditions or symptoms that apply to you.

Injuries/Trauma (list date next to injury):

__ Back injury
__ Head Injury/Concussion
__ Soft tissue injury
__ Broken bones/Fractures
__ Industrial accident
__ Sports Injury
__ Disability (ies)
__ Joint injury
__ Fall (severe)
__ Motor Vehicle Injury(ies)
__ Other

General History

__ Anemia
__ Fatigue/weakness
__ Mental illness
__ Bleeding/Bruising
__ Hospitalizations/surgeries
__ Skin lesions/rashes
__ Cancer
__ Autoimmune Disease
__ Unexpected Weight gain
__ Chills/Fever
__ Night Sweats
__ Unexpected Weight loss
__ Loss/change of appetite

Eyes/Ear/Nose/Throat

__ Eye/Visual problems
__ Hearing loss
__ Difficulty swallowing
__ Allergies/Sinusitis
__ Ringing in ears/dizziness
__ Frequent sore throats
__ Ear discharge/pain
__ Change in smell/taste
__ Swollen/painful glands
__ Frequent ear infections
__ Nosebleeds
__ Dental problems

Lung/Respiratory

__ Asthma/Wheezing
__ Coughing up blood
__ Toxic fume exposure
__ Cough
__ Pneumonia/infections
__ Tuberculosis/exposure

Heart/Cardiovascular

__ Heart disease/surgery
__ High/low blood pressure
__ Swelling of feet/ankles
__ Heart murmur
__ Palpitations
__ Shortness of breath with exercise

Stomach/Gastrointestinal

__ Abdominal pain/swelling
__ Jaundice/liver disease
__ Hemorrhoids
__ Heartburn/Ulcer
__ Constipation/diarrhea/gas
__ Rectal bleeding
__ Gallbladder disease/Stone
__ IBS/Crohn's Disease
__ Black tarry stools

Endocrine

__ Cold/heat intolerance
__ Excessive hunger/thirst
__ Unusual hair loss/growth
__ Diabetes
__ Hormone therapy
__ Voice changes
__ Hyper/Hypo Thyroidism

Nervous System

__ Dizziness/Fainting
__ Loss of memory
__ Slurred speech
__ Headache
__ Numbness
__ Stroke
__ Loss of consciousness
__ Seizures/Tremors
__ Unsteadiness of gait

Urinary System

__ Chronic bladder infections
__ Frequent urination
__ Pelvic/Flank pain/mass
__ Difficulty starting/holding
__ Kidney disease
__ Blood in urine
__ Kidney Stone

Female History

__ Abnormal vaginal bleeding/discharge
__ Cramps/pelvic pain
__ Hormone therapy
__Irregular menstruation
__ Fibroids/ovarian cyst
__ Hysterectomy
__ Breast lump/pain
__ Heavy menstrual bleeding
__ STD/STI
__ Frequent Yeast Infection/UTI

Concerns about your reproductive health: _____

Y/N I am pregnant Y/N I do have osteoporosis/penia
Y/N I am in menopause Y/N Birth control/method/How long_____
If you have been pregnant in the past, please fill in the appropriate information below.
_____ Number of Pregnancies ____ Number of Births
Last PAP date _____ Normal: Y N Last Mammogram date _____ Normal: Y N

Male History ONLY

__ Burning/frequent urination
__ Hesitancy/dribbling
__ Urine retention
__ Erectile dysfunction
__ Prostate disease/Enlargement
__ STD/STI
__ Testicular mass/pain
__ Last PSA test date _____

Family History: Please write who the relation is and how old they were when had the disease.

__ Alzheimer's _____
__ Headache _____
__ Backache _____
__ Heart disease _____
__ Cancer _____
__ High Blood Pressure _____
__ Depression _____
__ Stroke _____
__ Dementia _____
__ Tremors _____
__ Diabetes Type I/Type 2 _____

Medical History

Date of last physical exam and reason:_____

Date of last X-ray taken and reason:_____

Date of last MRI/CT taken and reason:_____

Date of last labs taken and reason:_____

Bone Density/ DEXA:_____

Have you ever experienced an aortic dissection aneurism? Y N

Is there a family history of aortic dissection aneurism? Y N

Is there a family history of Collagen disorders (i.e. Marfan's Syndrome)? Y N

Have you had disabling neck or arm pain, headache or concussion within past 6 months? Y N

Please list all current medications and supplements taken. Include frequency and dosage if known.

1._____

2._____

3. _____

4._____

CONSENT TO TREATMENT:
To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Dr. Ko of any changes in my health status at the beginning of future appointments. I agree to discuss my pregnancy as it progresses and I consent to treatment.

Signature: _____ Date: _____