Name: ______________________

Osteopathic Integrative Medicine

David Zarou, D.O. ***Erin Woessner, D.O.*** ***Dana Anglund, D.O.***

70 Broadway, Denver, CO 80203 Suite #200
(1st and Broadway on the SE side next to the Hornet Restaurant)
Phone: 303-350-7990 Fax: 303-217-5708
www.oimcare.com

This letter is to confirm that you are scheduled for a new patient appointment on

__________________. The time of your appointment is at ____________.

If you find that you would be unable to attend this appointment, please give our office a minimum of 24 hours notice. We save extra time for new patients, so if you cannot keep the appointment and do not call to cancel, it deprives other patients of time, therefore, you may be charged for a missed appointment without notice.

Please wear or bring comfortable "work out" loose clothing—no jeans, dresses or skirts.

We look forward to meeting you and assisting you with your health care needs.

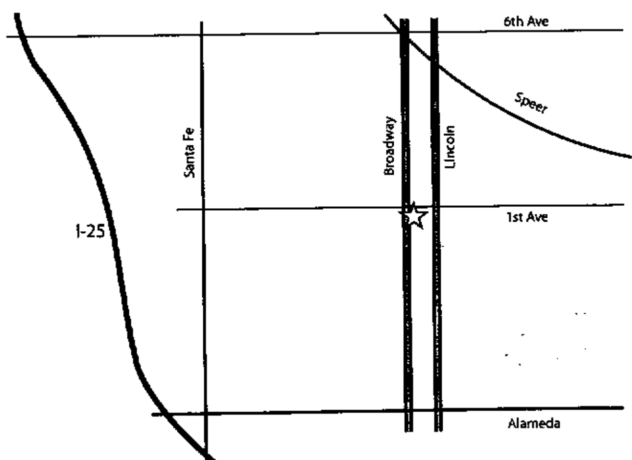
Sincerely,
Dr. Zarou, Dr. Woessner, Dr. Anglund and staff

There is parking available behind our building off 1st Ave. between Broadway & Lincoln Ave
Your First Appt will take over an hour, so please park in the back
The cost is $1.50 for 2 hours.
Enter through back door--3 story Red Brick building; we are on the 2ND floor

Directions from I-25: Take 6th Avenue east, to Broadway South, to 1st Ave left, then turn right into the parking entrance (right after the "Senor Burritos" red and orange building)

From 8th Ave. or Speer go West to Broadway South to 1st Ave. left, and turn right into the parking entrance

***VIEW** of building from BACK PARKING LOT*



OSTEOPATHIC INTEGRATIVE MEDICINE, INC.
70 Broadway Suite 200
Denver, CO 80203
303-350-7990
(f) 303-217-5708

Patient Questionnaire
(Please Print)

Name________________________________ Today's Date______________

What do you want to be called? _______________________________________

Social Security Number ____________________

Date of Injury/ Onset of symptoms ______________

Date of Birth ____________________ Age ____ Height ______ Weight _______

Chief Complaint ____
____
____

Briefly describe how your injury occurred: ______________________________
____
____
____
____

<u>If this was an Auto injury</u>- Was your seatbelt on? _____ Yes _____ No

Did you lose consciousness? _____ Yes _____ No

Did the airbag deploy? _____ Yes _____ No

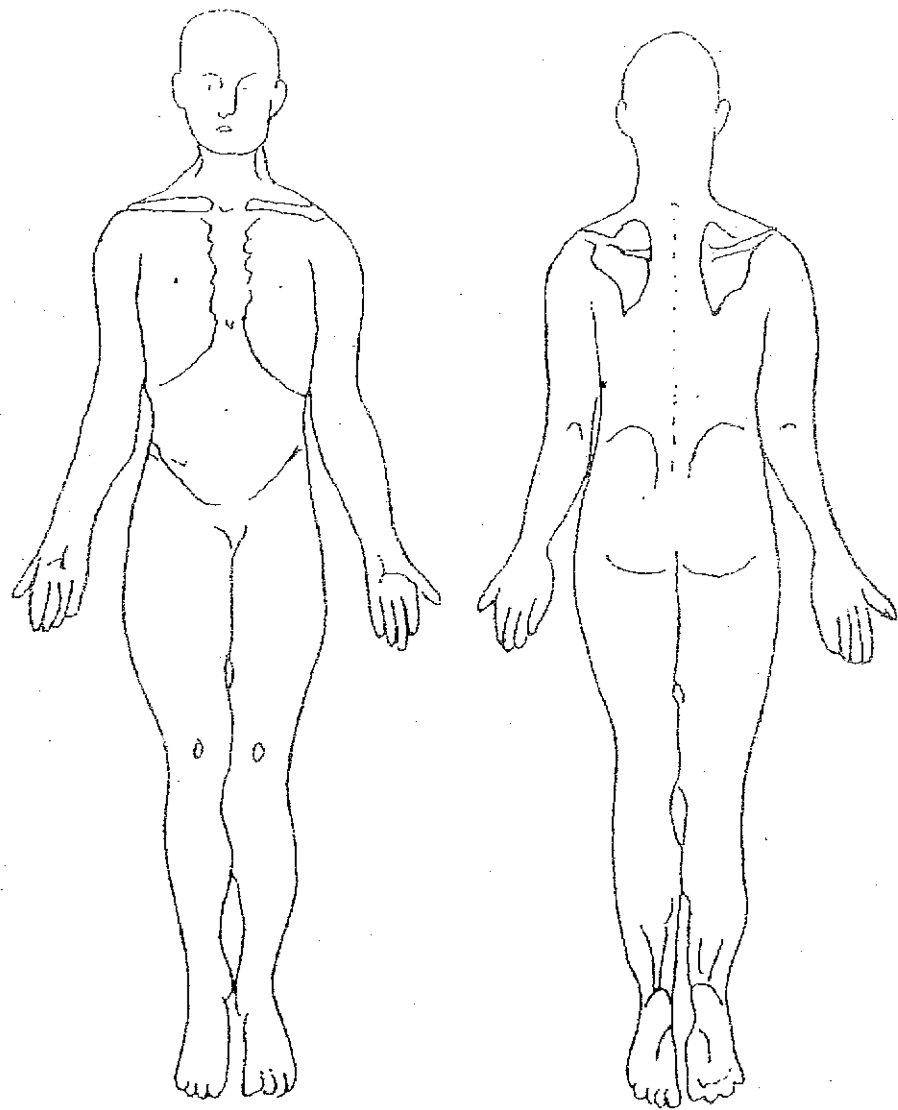
Did you see the accident coming (Did you brace yourself for impact?) ____ Yes ____ No

Did your vehicle hit anything else after the collision? _____ Yes _____ No

If yes, please explain ____
____
____

Using the symbols below, please draw in the location of your symptoms on the diagram.

XXX = Burning OOO = Numbness //// = Stabbing ^^^^ = Aching *** = Pins & Needles



Please mark the scales below to indicate the intensity level of your symptoms/pain. "None" on the left side of the scale indicates No Pain, and "10" on the right side of the scale indicates Severe Pain that might cause one to faint.

What is your worst pain?	None	1	2	3	4	5	6	7	8	9	10
What is your least pain?	None	1	2	3	4	5	6	7	8	9	10
What is your pain today?	None	1	2	3	4	5	6	7	8	9	10

INCREASE OR DECREASE OF SYMPTOMS/PAIN

	WORSE	BETTER	COMMENTS
Bending			
Bowel Movement			
Coughing/ Sneezing			
General Activity (explain)			
Sitting to Standing			
Lying Down			
Standing			
Walking			
Sitting			

How long can you stand with no or minimal pain? ____________________

How long can you sit with no or minimal pain? ____________________

Walking distance with no or minimal pain (circle one):

0-50 ft   50-200 ft   200-500 ft   500+ ft   ½ mile

Please indicate which Diagnostic Tests you have had in evaluation of your main complaint/problem:

Test:	Body Part/Date:	Test:	Body Part/Date:
Plain X-Ray		EMG/NCV/SSEP	
Bone Scan		Arthrogram	
Myelogram		MRI	
CT Scan		Dexa Scan	
Discogram		Other	

PAST TRAUMA HISTORY

Please list any injuries you have experienced in the past?

____

____

____

Have you had any prior auto / job injuries? _____ Yes ______ No

If yes, please describe the injury, list the date, and list the duration of time you were off work, if any.

Injury	**Date**	**Time Loss**

Please check which Treatments you have had for your main problem/complaint:

Treatment:	(check box)	Treatment:	(check box)
Electrical Stimulation		Massage	
TENS		Pool Exercises	
Ultrasound		Home Exercises	
Hot Packs		Manipulation	
Cold		Acupuncture	
Whirlpool		Injections	
Physical/ Occ. Therapy		Biofeedback	

PAST MEDICAL HISTORY
(Please check box if applicable)

Asthma		Pacemaker		
Bowel Disorders		Polio		
Cancer		Psoriasis		
Depression		Rheumatism		
Diabetes		Seizures		
Heart Disease		Serious Infection		
High Blood Pressure		Stroke		
Kidney/Liver Disease		Thyroid		
Lung Disease		Ulcers		
Multiple Myeloma		Migraine Headaches		
Osteoporosis		Other		
Anxiety		Other		

SURGICAL HISTORY
Please list any surgeries you have had:

Type: **Date:** **Outcome:**

___

___

___

Drug allergies and types of reactions:

___

___

___

Please list all current medications and dosages:

___

___

___

___

___

___

___

SOCIAL HISTORY & HABITS:

Who was your employer at the time of your injury? ______________________________

How long had you worked for them? ____

Working Status (circle one):

Employed: Y / N   Retired: Y / N   Unemployed: Y / N

Hours per week: ________________

Any Restrictions? _______________________________________

Who is your current employer? ____

Tobacco Use: Y / N   Type: _______ Quantity per day: _______ How Long? ________

Alcohol Use: Y / N   Type: ________________ Quantity per day __________________

Have you ever been treated for drug or alcohol addiction? Y / N

Marital Status: Married/ Life Partner / Single / Divorced / Separated
Number of Children _____

FAMILY HISTORY

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	AGE	ALIVE	DECEASED	ILLNESSES and/or CAUSE OF DEATH
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				
SIBLING 3				

How many hours do you sleep per night? ______________________________________

Do you have trouble falling asleep? ______ Yes ______ No

Do you have trouble staying asleep? ______ Yes ______ No

Do you feel well rested upon waking? ______ Yes ______ No

REVIEW OF SYSTEMS

(Please check next to the areas that apply to you.)

Constitutional

Weight gain- 6 months	Weight Loss- 6 months	Night Sweats
Chills	Fever	
Skin		
Easy Bleeding	Any Rashes	Easy Bruising
Eyes, Ear, Nose, And Throat (recent)		
Changes in vision	Changes in Smell	Any Dizziness
Changes in Hearing	Changes in Taste	Any Ringing
Respiratory		
Shortness of Breath	Sputum	Wheezing
Cough	History of Tuberculosis	
Cardiovascular		
Chest Pain	Shortness of Breath	Feet Edema
Palpitations	Heart Murmur	
Gastrointestinal		
Chewing	Swallowing	Indigestion
Nausea	Diarrhea	Abdominal Pain
Vomiting	Bloating	Bloody or Dark Stools
Constipation		
Reproductive		
Menstrual Problems	Pain w/ intercourse	
Possibly Pregnant	Difficulty Achieving /Maintaining Erections	
Genito-Urinary		
Blood in Urine	Unable to Control Bladder	Rushing to Urinate
Urinary Tract Infections	Need to Urinate frequently	
Musculoskeletal		
Cramps/Aches	Joint Pain	Joint Swelling
Attacks of Weakness	Morning Stiffness	
Central Nervous System		
Poor Appetite	Numbness/Tingling Feet	Crying Spells
Problem Sleeping	Numbness/Tingling Hand	Convulsions
Headaches	Fainting	

Patient Signature ______________________ Date ________________

The preceding patient information packet has been reviewed and discussed with the patient.

Physician Signature ______________________ Date ________________

WELCOME TO THE OFFICE OF
Osteopathic Integrative Medicine
303-350-7990

Welcome to our office and thank you for choosing us as your health care provider. We are committed to your treatment being successful and strive for you optimal health. We feel it is helpful to understand our office and financial policies prior to starting treatment. The following information makes it possible to offer you the highest quality of care.

INSURANCE BILLING:

As a courtesy to you, we will bill your insurance company when appropriate for the services performed at our office. However, you have ultimate responsibility for payment of your co-payments, co-insurance and deductibles. It is your responsibility to know what your deductible/co-insurance is. We will require payment at the time of service until the deductible is met.

Many insurance plans require pre-authorization for services, therefore, it is important to work closely with our medical staff, your primary care physician and your insurance company. It is important to follow the guidelines of the insurance plans and not exceed the authorizations given for care.

We understand that you may be working with a number of providers for your care and it maybe necessary for your personal/medical information to be shared with others. However, it is your responsibility to share this information. Please discuss your individual needs with our staff.

PATIENT PAYMENT:

Co-payment or payment for services **not** covered by insurance is required to be paid at the time of service. There will be a finance charge of 1.5% charged to accounts more than 30 days old and a $25.00 charge for all returned checks. Please discuss your individual needs with our staff.

APPOINTMENTS:

As a courtesy, you will be receiving a reminder phone call on day in advance of your appointment. Please notify our staff if you do not wish to be contacted or if you do not wish to receive a voice message regarding your appointment. In order to keep our schedule running smoothly, we ask that you arrive for you appointment on time. If you arrive more than 10 minutes late to an appointment, you may be re-scheduled.

We require a 24-hour cancellation notice. If you miss or cancel your first appointment without 24-hour notice, we will require a credit card number to re-schedule. If you miss it the second time, your card will be charged $140.00. Cancelled follow-up appointments, with less than 24 hours notice as well as no-shows, will be subject to a fee of $85.00 fee.

Three late re-schedules, no-shows, cancellations, or combination thereof may result in a discharge from our care.

MISCELLANEOUS:

Those with children are encouraged to consider outside babysitting arrangements, as our staff will be unable to supervise them for you. We wish to promote a quiet and relaxing atmosphere for you and all our patients.

Please understand that prescription refills, authorization for services outside of our office, referrals and/or special doctor requests may require a minimum of 48 hours to process. Please give our office enough notice to process requests in a timely manner.

If you have questions or concerns regarding these or other policies, please ask a member of our staff.

I have read, understand and agree to the provisions of this office/financial policy.

Signed____ **Date**__________