Name: ______________________

David Zarou, 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 and staff

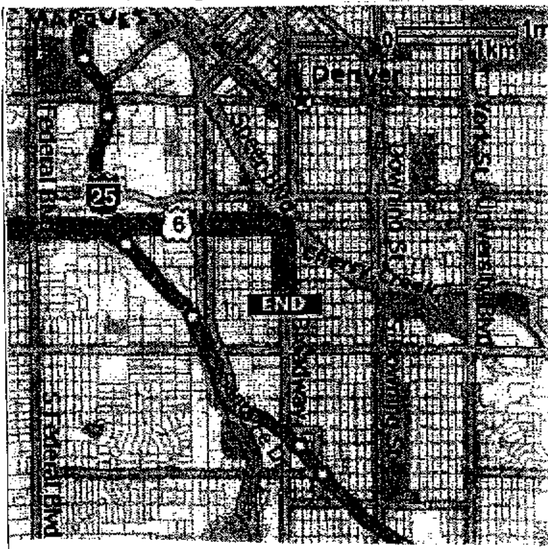
***Free Parking** available behind our building off 1st Ave. between Broadway & Lincoln Ave*

Your First Appt will take over an hour, so please park in the back

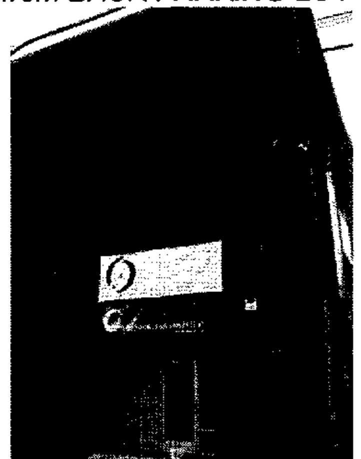
Enter through back door--3 story Red Brick building; we are on the 2ND floor

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" white 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*



ATTENTION: PARKING

We have gated parking available off of **1st Avenue** between Broadway and Lincoln St.

Depending on which way you are heading on 1st Avenue, turn south into the lot next to Senior Burritos (white building). Pull into the **second lot on the left** with the bright yellow polls. That is our lot even though it says Private Parking.

There will be a gate. We can validate your parking.

This is a building that is a work in progress. Please forgive the confusion

The back of our building is red painted brick with banners on it. Ours says: Osteopathic Integrative Medicine. Come on in and up to the second floor.

Your First Appt will take over an hour, so please park in the back so you won't get a ticket!

ALSO: IF YOUR APPT IS BEFORE 9:00AM

Make sure you park in the back because the front door is locked until 9:00am

OSTEOPATHIC INTEGRATIVE MEDICINE, INC.
David A. Zarou, D.O.
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

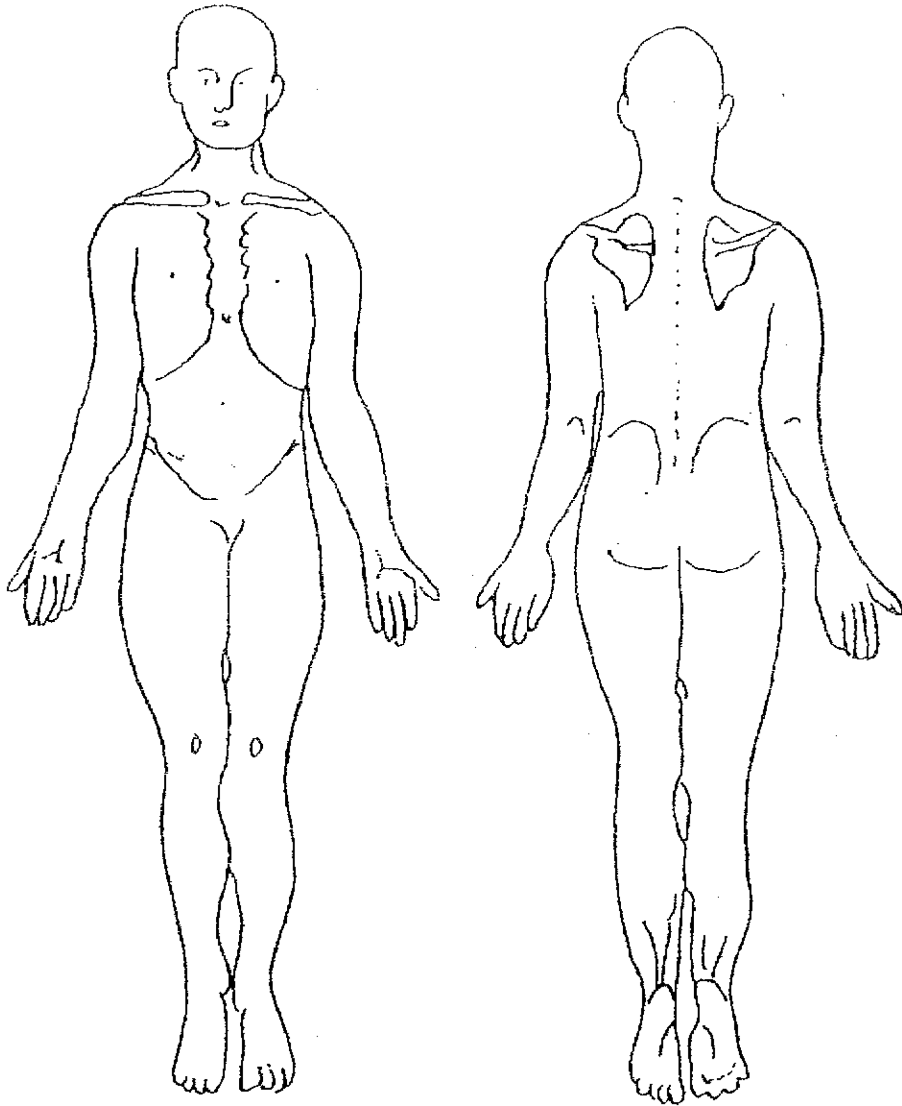
If yes, please explain ____

____

____

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	
Diskogram		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 you 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 / 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
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 ______________________