Osteopathic Integrative Medicine

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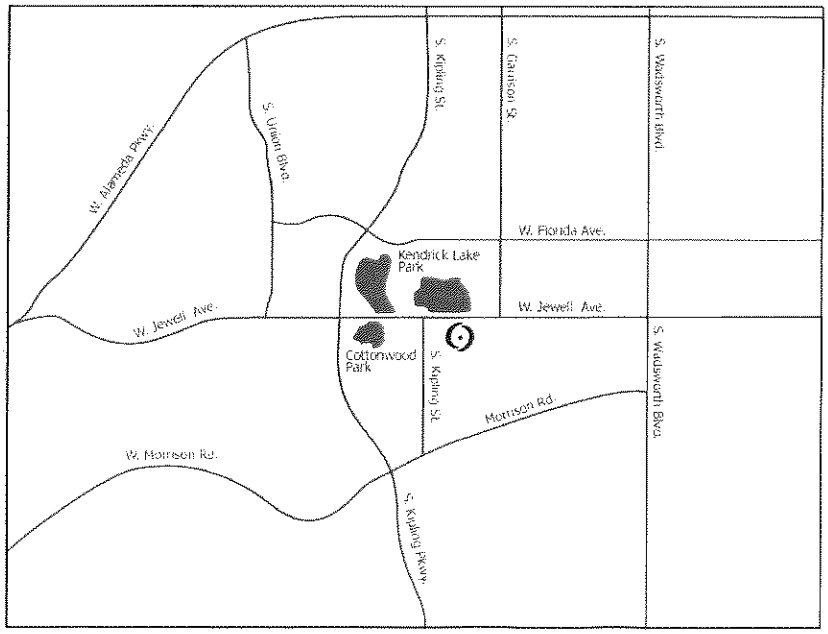
As of May 23, 2017, our office is located at:
9600 W. Jewell Ave, Ste. 3, Lakewood, CO 80232
(Kipling & Jewell, across the street from Kendrick Lake Park)
phone: 303-350-7990
fax: 303-217-5708
www.oimcare.com

This letter is to confirm that you are scheduled for a new patient appointment. If you find that you are 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.
We look forward to meeting you and assisting you with your health care needs. Please wear or bring comfortable "work out" loose clothing—no jeans, dresses or skirts. Also, please refrain from wearing heavy perfumes or cologne.



OSTEOPATHIC INTEGRATIVE MEDICINE, INC.
9600 W. Jewell Ave., Ste 3, Lakewood, CO 80232
(p) 303-350-7990
(f) 303-217-5708

Patient Intake

(Please Print)

Name_____ Today's Date_____

What do you want to be called? _____

Social Security Number _____ Right or Left Hand Dominant (circle one)

Date of Injury/ Onset of symptoms _____

Date of Birth _____ Age _____ Height _____ Weight _____

Chief Complaint _____
_____
_____

Briefly describe how your injury occurred: _____
_____
_____
_____
_____

If this was an Auto injury- 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

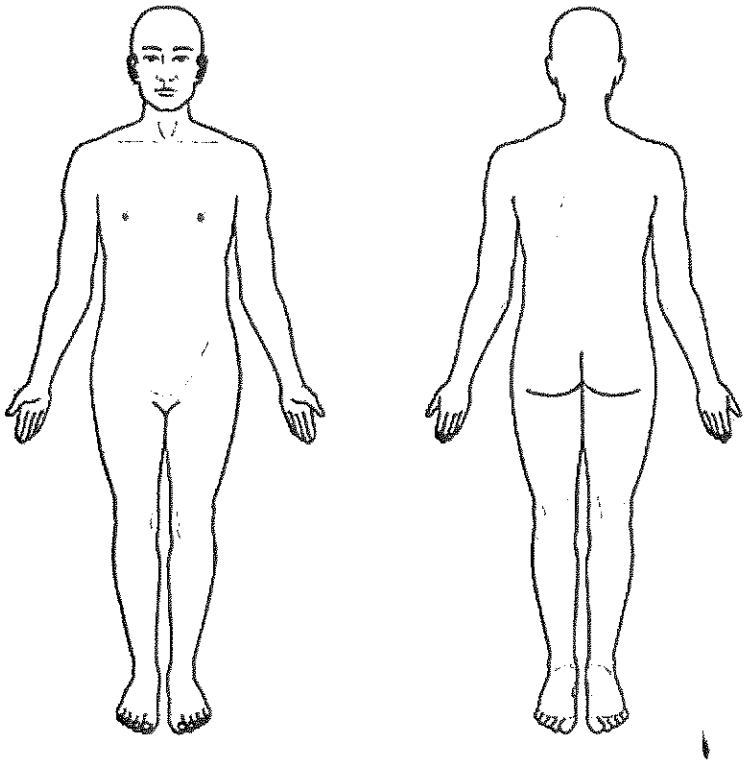
If yes, please explain _____
_____
_____

In an effort to best coordinate your care, may we please send a note to your Primary Care Physician? If so, please give us their first and last name, and phone number if available:
_____ Phone: _____

Are there any other providers you wish us to inform of your progress?
_____ Phone: _____

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			
Lifting			
Sitting to Standing			
Lying Down			
Standing			
Walking			
Sitting			
Climbing Stairs			
Other:			

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
What do you do for exercise? _____
Are you currently able to do all activities/exercises? _____

IMAGING

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:	✓	Helpful? (circle)	Treatment:	✓	Helpful? (circle)
Electrical Stimulation		yes/no	Massage		yes/no
TENS		yes/no	Pool Exercises		yes/no
Ultrasound		yes/no	Home Exercises		yes/no
Hot/ Cold Packs		yes/no	Manipulation		yes/no
Stretching		yes/no	Acupuncture		yes/no
Whirlpool		yes/no	Injections		yes/no
Physical/ Occ. Therapy		yes/no	Biofeedback		yes/no

Past Medical History:
(Please check box if applicable)

Anxiety		Hypothyroid		Rheumatism	
Asthma		Thyroid (other)		Seizures	
Bowel Disorders		Kidney/Liver Disease		Serious Infection	
Cancer (kind?)		Lung Disease		Stroke	
Depression		Multiple Myeloma		Ulcers	
Diabetes		Osteoporosis		Migraine Headaches	
Heart Disease		Pacemaker		Reflux/GERD	
High Blood Pressure		Polio		Other	
Hyperthydroid		Psoriasis		Other	

Drug Allergies and types of reactions:

_____

_____

_____

Medications:
(Please list all chronic, current, over the counter drugs, suplements and herbs)

Medication	Dose	Frequency	Start Date:	Stop Date:

Patient Name (Please Print): _____

SURGICAL HISTORY

Please list any surgeries you have had:

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

_____

_____

_____

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? _____

What is your occupation? _____

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 _____ Whom do you live with? _____

FAMILY HISTORY

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

	ALIVE/AGE?	DECEASED/AGE?	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: In the last **six months** have you experienced any of the following? (Please check next to the areas that apply to you.)

Constitutional		
Weight gain- lbs?	Weight Loss- lbs?	Night Sweats
Chills	Fever	
Skin		
Easy Bleeding	Any Rashes	Easy Bruising
Changes in Hair Growth		
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 Swelling
Palpitations	Heart Murmur	
Gastrointestinal		
Chewing difficulties	Swallowing difficulties	Indigestion
Nausea	Diarrhea	Abdominal Pain/Cramps
Vomiting	Bloating	Bloody or Dark Stools
Constipation	Reflux/Heatburn	
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	Pain with Urination
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	

In Case of Emergency: Name of local friend or relative:_____

Relationship to patient: _____ Phone Number: _____

Patient Signature _____ Date _____

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

Physician Signature _____ Date _____

NOTICE OF PRIVACY PRATICES (HIPPA)
OSTEOPTHIC INTAGRATIVE MEDICINE

The HIPPA privacy act went into effect on April 14, 2003.

The following is a basic summary of some of your rights regarding how we may use and disclose medical information about you:

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to nurses, technicians, medical students, other physicians, and/or hospital personnel who are involved in your care.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party (i.e. auto insurance).

At this time we do not accept auto insurance. We do treat auto-accident patients through their personal health insurance or through self-pay. It is the responsibility of the patient to submit receipts for any treatment for reimbursement for their auto case.

For Health Care Operations: Members of the staff may use information in your health record to assess the care and outcomes in your case and others like it. For example, we may combine medical information about many patients to evaluate the need for new services or treatment.

There is more information about your HIPPA rights at the office. Please ask our staff to provide a copy to you upon arrival.

I acknowledge that I was informed of the privacy practice of Osteopathic Integrative Medicine:

Date: _____

Patient's Name: _____

Patient's Signature: _____

Staff Signature: _____

WELCOME TO THE OFFICE OF
Osteopathic Integrative Medicine

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 to help you achieve 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:

We will bill your insurance company when appropriate for the services performed at our office. However, you have ultimate responsibility for paymant of your account. Please furnish our office with all of the necessary information required for billing your insurance.

PATIENT PAYMENT:

Co-payment or payment for services not covered by insurance is required to be paid at the time of service. $25.00 charge for all returned checks. There will be a finance charge of 1.5% charged to accounts more than 30 days old. 90 days without payment made to your account, will result is a 30% collection agency fee based upon the full balance due and your account will be sent to our collection agency. At this time we do not accept auto insurance. We do treat auto-accident patients through their personal health insurance or through self-pay. It is the responsibility of the patient to submit receipts for any treatment for reimbursement for their auto case.

Many insurane plans are moving into high deductible plans, we will check your insurance plan before your first visit and determine your approximate benefit plan. Those with high deductable plans will be charged $300.00 at the time of your first visit, and $150.00 for each follow up visit until the deductable is met. This is an approximate charge for your basic visits, all insurance policies differ and there is no way of predicting the exact amount insurance will ultimately charge you. If we charged too much, you will be refunded. Also, there are proceedures offered at this office that an additional charge.

APPOINTMENTS:

As a courtesy, you will be receiving a reminder phone call one 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. 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 of 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**_____