Maria Coffman, D.O.
Osteopathic Physician

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NEW ADULT PATIENT FORM

Name: ____
(First) (Middle) (Last)

Date of birth (MM/DD/YYYY): _______/_______/_______ Age: _____ Male Female

Reason for visit and duration of symptoms:____

Primary care practitioner: ____

Other practitioners you see (Ex, specialists, holistic practitioners, therapists)___________________________

____

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married

People and pets in household: ____

Occupation: ______________________ Ethnicity/cultural background: ______________________

Where did you grow up? ______________________

Do you have children? ☐ No ☐ Yes________________ Siblings? Brothers __________________Sisters ___________________

Highest level of education: ☐ 8th-12th grade ☐ High school ☐ Technical college______________________

☐ College # years_____ degree_______________ ☐ Graduate degree__________ ☐Professional school ___________________

Do you smoke? ☐ No ☐ Yes ______/PPD History of drug use? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes

Major life changes or events. *Please provide dates and details.*

☐ Change in job ___________________________ ☐ Birth of children_________________________________

☐ Re-located/moved household ____________ ☐ Death in the family_______________________________

☐ Change in marital status _______________ ☐ Major change in health ____________________________

Physical activities:____

Hobbies and interests: ____

ENVIRONMENTAL HISTORY

Home tested for lead? ☐ No ☐ Yes ☐ Not sure Home tested for radon? ☐ No ☐ Yes ☐ Not sure

What is the source of your drinking water? ☐ Well ☐ City ☐ Bottled ☐ Filtered, Type: __________

Are solvents, disinfectant chemicals or pesticides used in the home? ☐ No ☐ Yes ☐ Not sure

Do you watch TV, or use a computer or video game system? ☐ No ☐ Yes Time per day? _______________

Do you have any concerns regarding your health and environment? ____

PAST MEDICAL HISTORY

Allergies (Medications, Food, Environmental): ☐ None known ☐ See attached page

____ Reaction: __________________________________

____ Reaction: __________________________________

Medications, including vitamins, herbs, and supplements: ☐ None ☐ See attached page
Please include **name, brand, and dose**:

____ ____

____ ____

Tetanus- Pertussis Immunizations Up-to-Date? ☐ Yes ☐ No, because ____________________________________

Injuries, falls, accidents ____

Sutures/stitches ____

Head injuries (Ex. concussions)? ____

Fractures? ____

Hospitalizations? ☐ No ☐ Yes ____

Surgeries & Injections ☐ No ☐ Yes ____

Imaging (body area) ☐ **X-ray**_________ ☐ **CT**___________ ☐ **MRI**_____________ ☐ **US**_________ ☐ **Other**_____

Birth history (if available): Birthplace: City, State ___________________ Birth weight: _____________________

☐ Premature: _______ wks ☐ Full term: _______wks ☐ Post-term: ________ wks

☐ Stayed in ICU? ☐ Cesarean? ☐ Forceps or suction?

Development: Any history of developmental issues such as speech delay, motor delay, past therapies, or learning issues?

____

Please check the box for the patient or relative (including parents, siblings, grandparents, aunts, uncles, and cousins):

	Patient	Relative	Comments
Birth defects	☐	☐	
Premature births	☐	☐	
Ear infections	☐	☐	
Hearing problems	☐	☐	
Dental fillings	☐	☐	
Crown or Bridge	☐	☐	
Dental Braces/splints	☐	☐	
Clenching or grinding	☐	☐	
Eye/vision problems	☐	☐	
Asthma	☐	☐	
Allergies	☐	☐	
Sinus/ nasal	☐	☐	
Skin rashes/eczema	☐	☐	
Pneumonia	☐	☐	
Sore throats	☐	☐	
Heart problems	☐	☐	
High blood pressure	☐	☐	
High cholesterol	☐	☐	
Chronic diarrhea	☐	☐	
Chronic constipation	☐	☐	
Chronic abdominal pain	☐	☐	
Reflux/nausea/ vomiting	☐	☐	
Urinary infections/ kidney disease	☐	☐	
STD	☐	☐	

	Patient	Relative	Comments
Anemia/ blood problems	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Thyroid problems	☐	☐	
Growth problems	☐	☐	
Other endocrine/ gland issues	☐	☐	
Growing pains/ bone problems	☐	☐	
Scoliosis	☐	☐	
Neck or back pain	☐	☐	
Arthritis/ joint problem	☐	☐	
Chronic pain	☐	☐	
Muscular problems	☐	☐	
Swallowing problem	☐	☐	
Coordination problem	☐	☐	
Headaches	☐	☐	
Seizures	☐	☐	
Memory problems/ Alzheimer's	☐	☐	
Alcohol abuse	☐	☐	
Substance abuse	☐	☐	
School problems	☐	☐	
Learning problems	☐	☐	
Depression or mental illness	☐	☐	
Social difficulty	☐	☐	

MEN : Prostate issues? ☐ No ☐ Yes ____

WOMEN : Menstrual Issues? ☐ No ☐ Yes ____

Have you ever been pregnant? ☐ No ☐ Yes: ___# pregnancies, ____#miscarriage, ____#abortions, _____# premies, ____ # live birth

Any pregnancy or fertility concerns? ☐ No ☐ Yes ____

OTHER diagnoses or symptoms: ____

DENTAL-TMJ

Have you had braces? ☐ NO ☐ YES List ages and duration of treatment ____

____

Concern with "bite", the way the teeth come together? ____

DIETARY HISTORY

Typical breakfasts: ____

Typical lunches: ____

Typical dinners: ____

Typical snacks: ____

Drinks: ____

Preferences: (circle) Salty Sweet Crunchy Creamy Spicy Light-not filling

Foods avoided and why:____

Vegetables ☐ most meals ☐ daily ☐ 3x/week ☐ weekly | Fruits ☐ everyday ☐ 3x/week ☐ weekly

Any concerns regarding diet/nutrition/supplements? ____

SLEEP HISTORY

What time do you typically fall asleep?____

What time do you typically wake up? ____

Do you fall asleep easily? ☐ Yes ☐ No, because ____

How long does it take you to fall asleep? ____

Do you awaken during your sleep? ☐ No ☐Yes Is it a particular time?____

*Whom may I thank for your referral?*____

REGISTRATION INFORMATION

Please Print

Name First_______________________ MI_______ Last___________________________

Social Security ________-_______-__________ **Marital Status** S M D W (circle one)

Date of Birth ______ _____ ______ **Age** _____ **Sex** Male ____ or Female____
Month Day Year

Street Address____

City ______________________ State_______ Zip__________ - ________

Phone Numbers: **1st** # to call (_____) _______ - _________ Home - Work - Cell - Other - Message

2nd # to call (_____) _______ - _________ Home - Work - Cell - Other - Message

3rd # to call (_____) _______ - _________ Home - Work - Cell - Other - Message

Email Address ____

If patient is a minor, Parent's Names: Mother____________________ Father____________________

Employer ____

Address _____________________________ City______________State________Zip__________

Person Referring _________________________________

Address ____________________________ City______________ State_______ Zip__________

Phone # (_____) ______ - ___________

Preferred Pharmacy ______________________________ **Phone** (_____) _______ - _________

IN CASE OF EMERGENCY NOTIFY ____

Relationship ________________________ Phone (______) _______ - __________

The undersigned, do hereby agree and give my consent for Hands On Health, Maria Coffman D.O. to furnish all treatment medical care considered necessary. Payment will be made at time of service. Any account not paid under agreement be considered in default and will be referred for proper collection. All expenses incurred from such action shall be the reponisibility of the patient/responsible party including, but not limited to, collection charges, legal fees, etc.

____ _______________
Patient or Other Responsible Party's Signature **Today's Date**

Acknowledgement of Hands On Health HIPAA Policy

I have reviewed the Hands On Health HIPAA privacy policy which is summarized as follows:

a. Right to access/copy private health information (PHI)
b. Right to amend PHI
c. Right to restrict use or disclosure
d. Right to confidential communications
e. Right to an accounting of disclosures
f. Right to file a complaint

I am aware that the complete HIPAA policy for Hands On Health may also be accessed on website at HandsOnHealthDO.com or in the office.

PATIENT: ☐ Self ☐ Child

PATIENT'S NAME: ____

PATIENT'S DOB: _______/_______/________

PARENT'S/GUARDIAN'S NAME if patient is < 18 years-old:____

SIGNATURE: ____ DATE: _______________________