Osteopathic Manual Medicine Intake Form Supplement

Name: _____Date of Birth: _____

Date of Evaluation: _____

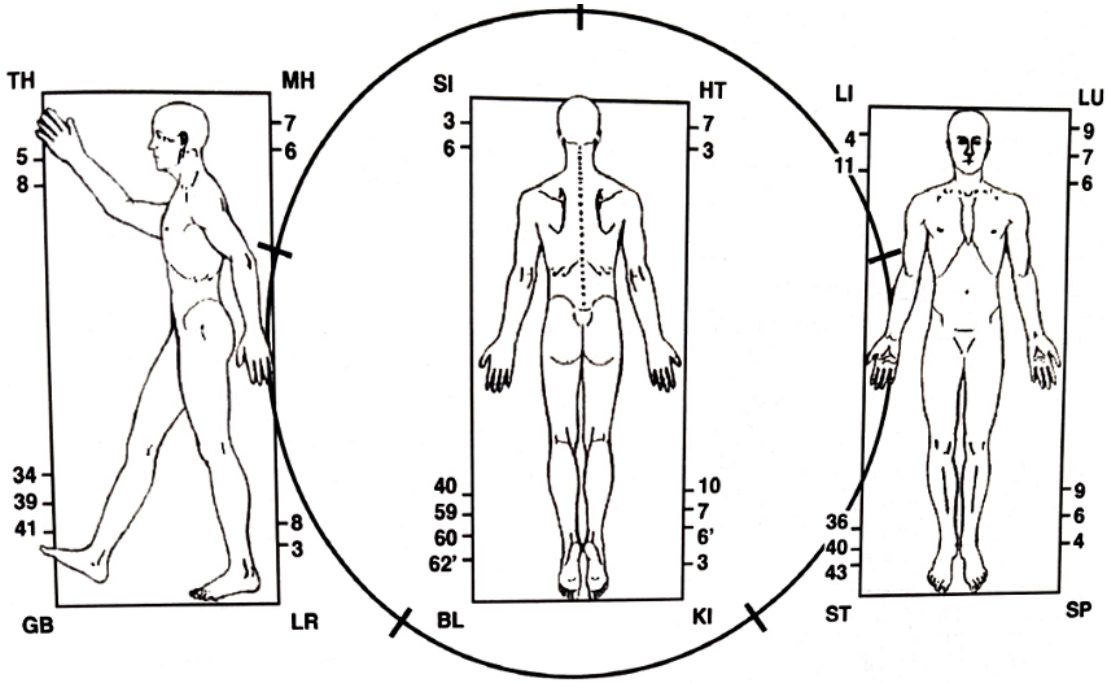
Main Concern(s):

1._____

2._____

3._____

Please mark areas of pain/symptom with X; O for tingling/numbness as accurately as possible.



Pain/Symptom Assessment- Side	Pain/Symptom Assessment- Back	Pain/Symptom Assessment- Front
Location: L/R/B	Location:	Location:
Onset:	Onset:	Onset:
Better with:	Better with:	Better with:
Worse with:	Worse with:	Worse with:
Associated symptoms:	Associated symptoms:	Associated symptoms:
Quality: ☐Constant ☐Intermittent ☐Dull ☐Sharp ☐Pressure ☐Burning	Quality: ☐Constant ☐Intermittent ☐Dull ☐Sharp ☐Pressure ☐Burning	Quality: ☐Constant ☐Intermittent ☐Dull ☐Sharp ☐Pressure ☐Burning
Severity: 1☐ 2☐3☐4☐5☐6☐7☐8☐9☐10☐	Severity: 1☐ 2☐3☐4☐5☐6☐7☐8☐9☐10☐	Severity: 1☐ 2☐3☐4☐5☐6☐7☐8☐9☐10☐

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How long have you had the pain/symptoms? _____

How often does the pain/symptom occur?

Continuous ☐ 1-2x day ☐ 3+x/day ☐ Few x/wk ☐ few x/month ☐

What activities were you doing leading up to your symptoms?

_____

Do the symptoms radiate from one area to another? _____

Are the symptoms more pronounced with any activity or position? _____

What imaging/testing has been done to evaluate your pain/symptoms? When?

1._____
2._____
3._____

What treatments have you tried previously (OMT/OMM/Chiropractic/Massage/Injections/Other)? How did they work?

_____

_____

_____

_____

_____

How do your symptoms limit your daily activities?

_____

_____

_____

How do these limitations affect your quality of life, including your relationships?

_____

_____

_____

Please complete Functional Rating Index

Thank you for completing this form.