Thomas H. Reece, DO, ND

PATIENT REGISTRATION FORM

(Please Print Clearly)

Date of your first APPOINTMENT: ________________________ TIME: ____________________

Patient Name____

Parent or Guardian (if patient is a minor) ____

Address ____

City ___________________________State _____________Zip________________

Home Tel________________________________Work Tel _____________________________

Fax ___________________________________Email address __________________________

Would you like to receive our emails? Yes_______ No_______

Date of Birth ____________________________ Sex: M ______ F _____Age ________________

Marital Status ___________________________Driver's Lic#________________________________

Current HEALTH INSURANCE Carrier ____

Insured's Name____________________Relationship___________________________________

Employer's Name ______________________________Insured's Birth Date: ________________

Employer's Address ____

____

Spouse's Name ___________________________ Work Tel _______________________________

Spouse's Employer/Address ____

Who is your current health practitioner or primary provider? ______________________________

Are you seeing another practitioner at PMCM? If so, who? _______________________________

Who referred you to PMCM? (Name)____

Address and Telephone____

Nearest Relative/Friend/Emergency Name & Tel____

____

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This information is strictly confidential. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. If you have any questions, please don't hesitate to call 415.472-2343.

Treatment Authorization

I hereby authorize Thomas Reece D.O., to provide medical services deemed necessary for the treatment of any illness or injury.

Please sign that you have read and understood and agree to this treatment authorization.

Signature ____ Date __________________________

Witness____ Date __________________________

Physician Thomas Reece, D.O________________________________ Date _________________________

Financial Responsibility

I, the undersigned, am financially responsible for all services provided to me and hereby agree that in the event of default in the payment of any amount due, and if the account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred and permits by laws governing these transactions.

Signed ____ Patient (if patient is an adult)

Signed ____ Guardian (if patient is a minor)

Date____

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Patient Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a “Privacy Rule” to help insure that personal health care information is protected for privacy., The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients) to request restrictions and revoke consent in writing.

Signature of Patient ____

Please print your name____

Date ____

Assignment of Insurance Benefits

I hereby assign all medical benefits to which I am entitled from my insurance company to
Thomas Reece, D.O. Osteopathic Physician. Mailing address: 25 Mitchell Blvd. Ste 8, San Rafael, CA 94903

Signature of patient____

Please print your name____

Date ____

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Chief Complaint

Main complaint

____

How long have you had this problem?

____

What seems to cause this problem?

____

Have you been given a diagnosis? __YES __NO

If yes, what? ____

By whom? Physician's name and phone number ____

____

To what extent does this problem interfere with your daily activities (work, exercise, sleep, sex, etc.)?

____

____

____

What kinds of treatment have you tried? How did your condition change?

____

____

____

What makes it better?

____

What makes it worse?

____

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PLEASE RATE YOUR CURRENT PAIN/DISCOMFORT ON THE FOLLOWING SCALE:

0=Absolutely No Pain   10=Unbearable Pain

Circle the number that best describes your pain at its WORST in the last month or since your last visit

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain at its LEAST in the last month or since your last visit

0 1 2 3 4 5 6 7 8 9 10

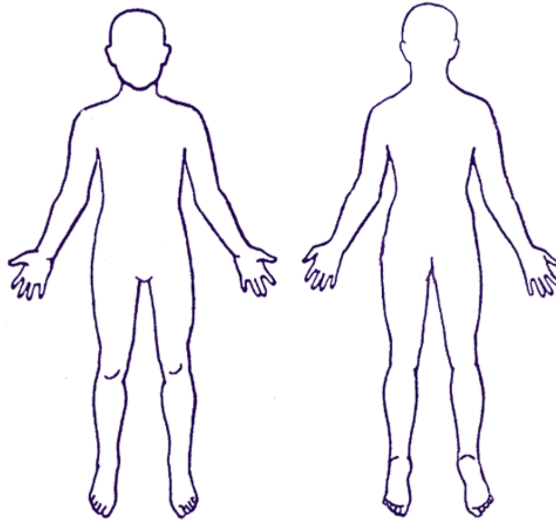
Circle the number that best describes your pain AT PHYSICIAN'S OFFICE

0 1 2 3 4 5 6 7 8 9 10

****

Mark the areas on the diagrams where you experience discomfort or pain with an X

FRONT   BACK



Circle the words that describe the pain:

Aching Sharp Penetrating Continuous Tiring Tender Nagging Tingling Miserable

Shooting Stabbing Intermittent Gnawing Burning Throbbing Exhausting Numb Unbearable

Other (explain)____

Circle the words that describe the pain:

Aching Sharp Penetrating Continuous Tiring Tender Nagging Tingling Miserable

Shooting Stabbing Intermittent Gnawing Burning Throbbing Exhausting Numb Unbearable

Other (explain)____

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Medical History

Please check any of the following which have ever affected you and indicate year and approximate age at time of onset. Information not checked is assumed to be negative.

__Addiction
__AIDS
__Alcoholism
__Anemia
__Appendicitis
__Arteriosclerosis
__Arthritis
__Asthma
__Breast lumps
__Breathing problems
__Bronchitis
__Bursitis
__Cancer
__Candida
__Chicken pox
__Chronic fatigue
__Eating disorder
__Elev. liver enzymes
__Emotional imbalance
__Emphysema
__Epilepsy
__Fibromyalgia
__Food, chemical, or drug poisoning
__Colitis or Bowel Disease
__Diabetes
__Digestive disorders
__Gall stones
__Glaucoma
__Goiter
__Gout
__HIV positive
__Heart disease
__Hepatitis or Liver disease
__Hernia
__High cholesterol
__Herpes
__Hypertension
__Hypotension
__Kidney stones
__Malaria
__Measles
__Meningitis
__Mononucleosis
__Multiple sclerosis
__Mumps
__Nephritis
__Neuralgia
__Paralysis
__Prostate problems
__Rheumatism
__Scarlet fever
__Seizures
__Stroke
__STD
__Thyroid problems
__Tonsillitis
__Tuberculosis
__Typhoid fever
__Ulcers
__Urinary problems
__Whooping cough

Other____

____

SURGERIES (Describe and List Date)____

____

HOSPITALIZATIONS AND SIGNIFICANT TRAUMAS (auto accidents, falls, loss of loved ones, etc.), and approximate date and your age at the time.

____

____

____

Were you healthy as a child? __YES __NO If no, list health challenges
____

____

Major dental work and dates____

____

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Family Medical History

Please check the appropriate columns for any illnesses that you or your relatives have had:
Age (if living) Health (good, fair, poor) G-F-P Age at death (if deceased)

__Arthritis
__Cancer (what type?)
____
__Diabetes Heart disease
__High blood pressure
__Stroke
__Alcoholism/Drug addiction

__Epilepsy/convulsions
__Skin conditions/ eczema
__Allergies/ hay fever Anemia
__Kidney disease
__Tuberculosis
__Thyroid disease
__Bleeding problems

__Digestive conditions
__Genetic diseases (what type?)
____
__Headaches (what type?)
____

How do you feel about the following areas of your life?

GREAT("GT") GOOD ("GD) FAIR ("F") POOR ("P") BAD ("B")

_____Significant other _____Family _____Diet / nutrition _____Sexuality _____Self _____Work _____Spirituality

Comments on above:____

Personal / Social History

Describe a typical meal
Breakfast____

____

Lunch____

____

Dinner____

____

Snacks____

____

To Drink____

____

Assuming that all foods are good for you, what are your three favorite foods or treats?
____

____

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Do you crave any food(s) or flavors?
____

What kind of work do you do? If you are retired, what kind of work did you do before retirement?
____

Who lives with you or who do you live with?____

Do you have a spiritual practice? If so please describe.
____

____

Do you exercise? __YES __NO What kind? How often?
____

____

____

Hobbies? __YES __NOIf so, please describe
____

____

DO YOU (Answer “Y” for “Yes” and “N” for “No”. Add comments if appropriate)

__Get an Average 6–8 hours sleep per night? ____
__Have trouble getting to sleep? ____
__Often wake up during the night? ____
__Feel rested in the mornings? ____
__Have a supportive relationship? ____
__Have a history of abuse? ____
__Have a history of trauma? ____
__Enjoy your work? ____
__Take vacations? ____
__Spend time outdoors? ____
__Do you smoke? How much?_____________________ For how long?____________________________
__Did you ever smoke? Cessation date _____________How many per day ________For how many years?______
__Use recreational drugs? Type______________________ Amount____________ Since when_______________
__Sleep on your side? Back? Stomach?____
__Watch television? How many hours weekly____
__Use computer for entertainment? How many hours weekly?______________________________________
__Do you drink coffee? How much daily? ____
__Do you drink tea? How many cups?____
__Do you drink soda? How many daily?
__Do you use alcohol? What Type?______________How Much?_____________ How Often?______________

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Review of Symptoms

List "P" for "PAST", "C" for "CURRENT" CONDITION
Please check any of the following which have ever affected you and indicate year and approximate age at time of onset. Information not checked is assumed to be negative.

General

__Poor appetite_______________
__Excessive appetite __________
__Strong thirst ________________
__Poor sleeping / insomnia ______
__Fatigue___________________
__Night sweats________________
__Sweat easily _______________
Swollen glands _______________
Frequent infection / chronic _____
Allergies_____________________
Fever_______________________

Chills________________________
Localized weakness ___________
Bodily heaviness ______________
Weight loss __________________
Weight gain __________________
Hot or cold intolerance _________
Cold hands or feet _____________
Shortness of breath ____________
Poor coordination _____________
Bleed or bruise easily___________
Tremors _____________________

Mood change ________________
Nervousness / irritability ________
Sudden energy drop When?
____
Slow wound healing____________
Craving for sugar ______________
Other_______________________
____
____

Head, eye, ears, nose and throat

__Dizziness__________________
__Headache _________________
__Migraine
____
__Concussions / head injury_____
__Facial pain_________________
__Sore throat ________________
__Sores on lips or tongue_______
__Grinding teeth_______________
__Jaw clicks / pain ____________
__Gum problem_______________
__Teeth problems / braces ______
__Excessive saliva ____________

__Color blindness_____________
__Recent change in vision______
__Cataracts__________________
__Glaucoma__________________
__Spots in the eyes____________
__Night blindness______________
__Blurry vision________________
__Eye pain___________________
__Dry eyes___________________
__Red eyes __________________
__Itchy eyes__________________
__Excessive phlegm___________
__Ringing in ears______________

__Poor hearing________________
__Ear pain___________________
__Vertigo____________________
__SInus problems_____________
__Runny nose________________
__Sneezing __________________
__Nasal congestion ____________
__Swollen glands _____________
__Peculiar smells _____________
__Peculiar tastes ______________
__Goiter ____________________
__Nose bleeds _______________
__Other_____________________

Cardiovascular / vascular

__High blood pressure_________
__Low blood pressure _________
__Blood clots________________
__High cholesterol____________
__Poor circulation_____________
__Irregular heartbeat___________
__Palpitations________________
__Chest pain_________________
__Heart murmur_______________

_Heart valves problems_________
__Fainting___________________
__Swelling of hands ___________
__Swelling of ankles / feet______
__Cold hands or feet__________
__ Anemia___________________
__Stets Heart_________________
__Rheumatic fever_____________
__Angina____________________

__Heart attack________________
__Pacemaker_________________
__Heaviness to legs____________
__Easy bruising_______________
__Varicose veins______________
__Leg cramps________________
__Other_____________________
____

Respiratory

__Pain with deep breath________
__Tightness of chest___________
__Difficulty breathing when lying down_______________________

__Sleep apnea_______________
__Frequent colds / flu_________
__Phlegm Color _____________

__Other_____________________
____

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Gastrointestinal/Genito-Urinary

__Constipation________________
__Diarrhea___________________
__Blood in stool_______________
__Undigested food in stools_____
__Foul-smelling stools_________
__Black stools________________
__Light-colored stools_________
__Burning sensation of anus____
__Rectal pain_________________
__Hemorrhoids________________
__Chronic laxative use_________
__Nausea / vomiting__________
__Vomiting blood_____________

__Hiccups ___________________
__Belching___________________
__Bad breath _________________
__Ulcers ____________________
__Other_____________________
__Increased libido _____________
__Decreased libido ____________
__Other _____________________
__Pain on urination ____________
__Urgency to urinate ___________
__Decrease in urine flow _______
__Blood in urine ______________
__Frequent urination ___________

__Nighttime urination___________
__Incomplete feeling after urination ___________________
__Unable to hold urine _________
__Bedwetting_________________
__Urinary tract infections________
__Kidney infections____________
__Sore on genitals ____________
__Itchiness on genitals _________
__STD______________________
__Herpes Current_____________
__Other_____________________
____

Male Reproductive

__Erectile dysfunction___________
__Ejaculation during sleep_______
__Sperm in urine________________

Female Reproductive

If you are post-menopause, please describe your pre-menopausal menstruation.

If you are pre-menopausal:
Any possibility you are pregnant? _____
Are you sexually active?_____
Sexual difficulties? _____
Birth control?_____
STD? Describe
Date of last pap smear_____________________

Pregnancy
pregnancies______ # births _______ # miscarriages_______ # abortions__________ # premature births__________

Menstruation
Age of first period__________ Number of days between periods__________ Number of days of flow__________
Color of flow ___________ Start date of last flow __________

Menopause
Age at start of menopause__________ Menopausal symptoms__________

Menstrual flow

__Heavy
__Light
__Sexual difficulties?
__Clots
__Painful

__Spotting between periods
__PMS symptoms
__Pain with defecation
__Incomplete feeling of defecation

__Gas / bloating
__Indigestion / heartburn
__Abdominal cramps

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Musculoskeletal / neurological

__Dizziness ___________________	__Knee pain___________________	__Numbness __________________
__Arthritis ____________________	__Muscle weakness ___________	__Tingling ____________________
__Muscle spasms _____________	__Muscle pain / soreness ______	__Paralysis ___________________
__Neck tightness/pain __________	__Joint sprain ________________	__Cramps ____________________
__Shoulder pain ______________	__Joint disorders ______________	__Light-headedness ___________
__Hand / wrist pain ____________	__Scoliosis __________________	__Memory loss________________
__Back pain__________________	__Hernia ____________________	__Other_____________________
__Hip pain ___________________	__Seizures___________________	______________________________
__Sciatica ___________________	__Tremors ___________________	

Environmental Allergies

____

____

Medications

MEDICATION	DOSAGE	REASON	HOW LONG	LAST CHECKUP DATE
___________________	___________________	_______________	______________	_________________________
___________________	___________________	_______________	______________	_________________________
___________________	___________________	_______________	______________	_________________________
___________________	___________________	_______________	______________	_________________________

Medication Allergies

Medication____

Reaction ____

Medication____

Reaction ____

Supplements, Vitamins, Homeopathics

SUPPLEMENT	TAKING FOR	DOSAGE	HOW LONG?
___________________	___________________	_______________	_________________________________
___________________	___________________	_______________	_________________________________
___________________	___________________	_______________	_________________________________
___________________	___________________	_______________	_________________________________

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Additional information

Please use this page to tell the us anything else you feel would assist him to better diagnose and treat you.

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