ND MVA INTAKE FORMS
CONFIDENTIAL PATIENT CASE HISTORY

GRAHAM Rehabilitation & Wellness

This confidential history will be part of your permanent records.

Dr. Bahareh Moshtagh, ND
PLEASE NOTE THAT FILLING OUT THIS PAPERWORK CAREFULLY, MEANS THAT TIME WILL BE SPENT MORE EFFICIENTLY WITH PHYSICIAN

Today's Date: / / Patient's Signature:_____

SSN:_____ Parent/ Spouse/ Guardian Signature: _____

Title: (*Circle)* Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name_____Nick Name: _____

Last Name: _____Middle Name: _____

Address: _____

City: _____State: _____ Zip code: _____

Mobile Phone: _____Home Phone: _____

E-mail: _____ Best contact method? _____

Can we leave personal information on your voicemail or in e-mail? □ No □ Yes

DOB: MM /DD /YYYY Age:_____ Gender: □ Male □ Female □ Unspecified

Current occupation? Employer?: _____

Race: _____Ethnicity:_____

Verification Question: *(Choose only one question by checking the question, then give the answer to that question)*

□ Name of your favorite pet? □ Make of first car? □ Favorite color?
□ Favorite movie? □ Birth city? □ Street you grew up on?

Verification answer to chosen question: _____

Who referred you to us/ How did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Is this condition: □ Improving □ Unchanged □ Getting worse

Is this condition interfering with: □ Work □ Sleep □ Daily Routine □ Other:_____

MEDICATIONS & SUPPLEMENTS: *(Please list brand names)* □ None

Name:	Dose:	Reason:

HEALTH HISTORY

1. Have you been exposed to chemicals/ radiation? □ Never □ Yes, specify:

   _____

   (mechanics, dentists/dental assistance, environmental exposures etc.)

2. **Tobacco use:** □ Never □ Yes □ Former smoker

□ Vape pen containing nicotine □ Cigarettes □ Chewable tobacco *(# yrs?)*_____

Age you began smoking:_____ Age you quit smoking:_____ Total # of years you smoked:_____

Number of cigarettes a day or week (*specify*):_____ *(20 cig in one pack)*

3. **Alcohol use:** Oz a day/ week:_____ Type of alcohol:_____ # years?_____
4. **Drug use:** Type:_____ Frequency:_____ *(note this is confidential)*

   _____

5. **Caffeine intake:** Oz a day/ week:_____ # years?_____
6. **Have you been presently diagnosed with Hypertension? □ No □ Yes**
7. **Have you been presently diagnosed with Diabetes? □ No □ Yes**

   If YES, □ **Type I** □ **Type II Recent HbgA1c value?_____%**
8. **Have you been diagnosed with cancer? □ No □ Yes Type: _____**
9. **Do you have any implants or other foreign objects in your body? □ No □ Yes, Explain:_____**

   _____

ALLERGIES: *(Environmental/ Food/ Previous Injections)* □ None
(please specify anaphylaxis and other symptoms)

To what:	Onset:	Symptoms experienced:

- Do you have an up to date **Epi- Pen** and know how to use it? □ No □ Yes
- Have you ever been diagnosed with **Asthma**? □ No □ Yes
    - Do you have an **albuterol** inhaler? □ No □ Yes

PAST MEDICAL HISTORY

Provider(s) *(include title)***:** **Name:** **Name:** **Name:** **Name:**	 **Number:** **Number:** **Number:** **Number:**
Prior Injuries/ Hospitalizations/ Surgeries: - - - - - -	**Dates:** - - - - - -
Conditions you have been diagnosed with: - - -	- - - -
Chronic use of antibiotics?	**If yes, when and which types?**

CONCUSSION/ MOTOR VEHICLE INJURY ASSESSMENT

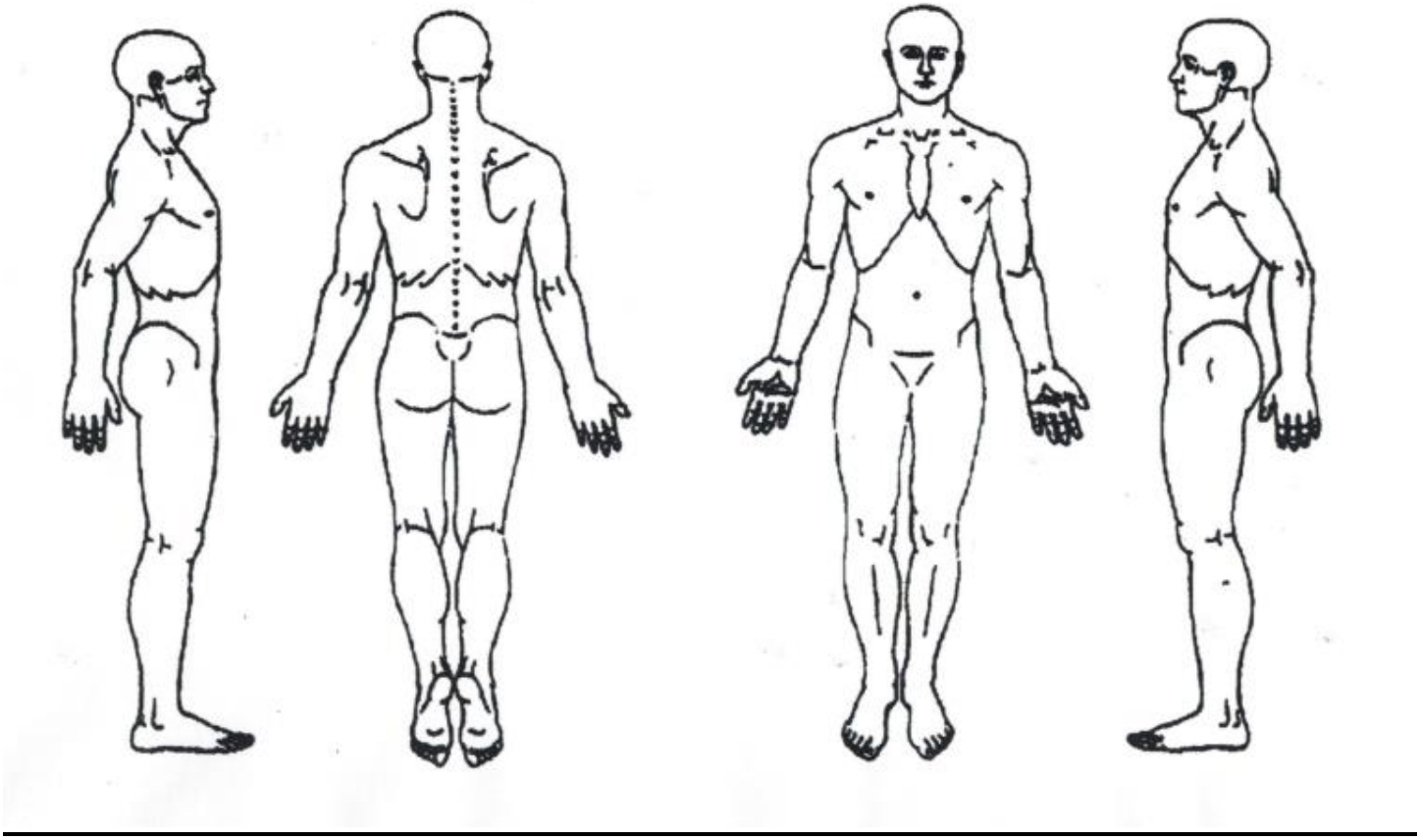
- What type of accident was this concussion due to? □ Car □ Bike □ Sports □ Fall
- Date & time of accident:____/___/_____;_____:_____AM/PM_____
- Location of accident: City/Town _____ State:_____
- Were you: Driver / Passenger/ Pedestrian
- Were you holding on to the steering wheel? □ No □ Yes
- Did you brace your arms against the dash? □ No □ Yes
- Did the vehicle spin or roll as a result?
- Which seat were you in? Front seat/ left rear seat/ right rear seat
- What type of vehicle were you in?_____
- What type of vehicle was the other vehicle?_____
- Where was the impact: Front / Rear/ Left side/ Right side
- What was the approximate speed at the time of impact:
    - Your vehicle: mph Other vehicle: mph
- Weather at time of collision:_____
- Was the car in: Neutral / Parked / Stopped/ In gear / Moving
- Were your breaks being applied? □ No □ Yes
- Was your vehicle shoved: Forwards/ Backwards/ Sideways
- Were you shoved: Forwards/ Backwards
- Did parts of your body hit the interior parts of the car?
- Did you lose consciousness? □ No □ Yes; For how long?_____
- Were you wearing a seatbelt? □ No □ Yes
- Airbags deployed: Front/ Side
- At the point of impact which way was your head facing? _____
- At the point of impact where did you experience pain? _____
- Did you go to the hospital; when; how? _____
  _____
- Imaging taken at the hospital; what types; what body parts? _____
  _____
- Name of hospital? _____
- Please describe the collision in your own words: _____
  _____
  _____
  _____
- Have you returned to school or work since? How has this transition been?
  _____
  _____
- How much time have you lost from this injury?
  _____

<u>Identify the areas of discomfort using the following key:</u>

Pain: Sharp X Dull Ache O Grade each out of 10 (10 worst pain)

Weakness: ~ Grade each out of 10 (10 worst weakness)

Numbness & Tingling: /// Grade each out of 10 (10 worst)



FAMILY HISTORY

(Please list any history of major illnesses: Autoimmune, Cancer, Heart Disease etc.)

Relative	**Condition**	**Age at diagnosis**	**Deceased age** *(ignore if living)*
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Brother(s)			
Sister(s)			

SOCIAL HISTORY

- **Living arrangements:_____**
- **Highest degree earned: _____**
- **Current stressor(s):_____ Grade of stressor: /10 (10 worst)**
    - **What are you currently doing to manage your stress?_____**
- **Exercise:**
    - **Type: _____**
    - **Number of times per week: _____**
    - **Amount of time per session: _____**
    - **Intensity: □ Heavy □ Moderate □ Light**
- **24 Hour Diet Recall (Can also give typical diet)**
        - **Food's you avoid: _____**
        - **Why? _____**
    - **Breakfast: _____**
    - **Lunch: _____**
    - **Dinner: _____**
    - **Snacks: _____**
    - **Water intake:_____Oz/ day**
- **Sleep:**
    - Difficulty staying asleep? □ **No** □ **Yes** Difficulty falling asleep? □ **No** □ **Yes**
    - Wake up feeling rested? □ **No** □ **Yes**
    - Hours of sleep on average per night? ___ consistent/ inconsistent? (*Circle)*
    - What time do you get into bed?
    - What time do you fall asleep?
    - What time do you wake up?
    - Rate your energy: ____/10 (10 being the most amount of energy)
    - Do you use a CPAP machine and have been diagnosed with sleep apnea?

REVIEW OF SYSTEMS

(Check only the ones you have or have had in the past)

Height: ' ft'in **Weight: lbs**

CONSTITUTIONAL	**□ NOW**	**□ PAST**
Unexplainable weight loss	☐	☐
Unexplainable weight gain	☐	☐
Fatigue / sleepiness	☐	☐
Fever	☐	☐
Chills	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Night sweats that soak through the sheets?	☐	☐

Alcohol consumption prior to sleep?

□ **No** □ **Yes**

PSYCHIATRIC	**□ NOW**	**□ PAST**
Depression	☐	☐
Loss of interest/ pleasure	☐	☐
Anxiety	☐	☐
Suicidal thoughts	☐	☐
Mood changes	☐	☐
Irritability	☐	☐

Diagnosed with a psychiatric disorder? *(List)*

_____

SKIN	**□ NOW**	**□ PAST**
Color changes	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐
Dry	☐	☐
Itchy	☐	☐
Rashes	☐	☐
Unusual moles	☐	☐
Hair loss on scalp	☐	☐
Increased hair in undesirable areas?	☐	☐
Brittle nails/ white lines/ indentations	☐	☐

IMMUNE	**□ NOW**	**□ PAST**

History of autoimmune diseases?

☐MS ☐RA ☐Hashimoto's ☐Graves ☐Lupus

Sick often? □ **No** □ **Yes**

LYMPHATIC/ BLOOD	**□ NOW**	**□ PAST**
Palpable non-painful nodes/ glands *(in neck, armpit, groin regions)*	☐	☐
Palpable painful lymph nodes/ glands	☐	☐
Red streaks and inflammation	☐	☐
Easy bruising	☐	☐
Easy bleeding	☐	☐
History of anemia	☐	☐
Diagnosed with a blood clotting disorder? Which: _____	☐	☐
Swelling of extremities	☐	☐

Worse in the beginning or end of the day?

_____

How long has this been going on?

_____

EYES	**□ NOW**	**□ PAST**
Changes in or loss of vision	☐	☐
Double vision/ blurry vision	☐	☐
Do you wear corrective Glasses? Contacts? *(circle)*	☐	☐
Eye pain	☐	☐
Watery eyes	☐	☐
Itchy or red eyes	☐	☐
Dry eyes	☐	☐
Eye discharge	☐	☐
Sensitivity to light	☐	☐
Sensitivity to sound	☐	☐
Trip over things a lot	☐	☐
Cataracts	☐	☐

o Farsighted (hyperopia) (can see far)
o Nearsighted (myopia) (can see near)

Date of last eye exam:_____

EARS	**□ NOW**	**□ PAST**
Ringing	☐	☐
Decreased hearing	☐	☐
History of frequent ear infections	☐	☐
Tubes in ears	☐	☐
Discharge	☐	☐
Ear pain	☐	☐

Diagnosed with BBPV/ vertigo/ meniere's ?

_____

NOSE □ NOW □ PAST

Nosebleeds □ □
Runny nose □ **No** □ **Yes**
Color?_____
Sneezing □ **No** □ **Yes**
Sinus pressure/congestion □ **No** □ **Yes**
Pain, pressure around the eyes □ **No** □ **Yes**
Postnasal drip □ **No** □ **Yes**
Nasal polyps □ **No** □ **Yes**

MOUTH □ NOW □ PAST

Mouth sores □ □
Easily bleeding gums □ □
Cold sores □ □
Toothache □ □
Frequent cavities □ □
Loose teeth □ □
Teeth grinding □ □
Dentures? □ **No** □ **Yes**
TMJ issues □ □

THROAT

Sore throat □ **No** □ **Yes**
Hoarseness/ change in voice □ □
Difficulty swallowing □ □
Dry mouth □ □
Throat swelling or constriction □ □
Swelling of neck □ □

MUSCULOSKELETAL □ NOW □ PAST

Muscle aches and cramps □ □
Changes in range of motion of □ □
Arms □
Legs □
Fingers □
Toes □
Knees □
Hands □
Back □
Hips □
Joint pain □ □
Joint stiffness □ □
Joint swelling □ □
Specify joints:_____
Scoliosis □ □

NERVOUS SYSTEM □ NOW □ PAST

Decreased sense of taste □ □
Decreased sense of smell □ □
Muscle weakness □ □
Changes in coordination, walking and balance? □ □
Seizures or convulsions □ □
Epilepsy □ □
Tingling/ numbness in fingers, toes, arms, legs □ □
Tremors at rest or with movement □ □
Ticks □ □
Misplacing items/ losing items □ □
Difficulty concentrating □ □
Difficulty remembering things □ □
Difficulty finding words □ □
Difficulty planning things □ □
Difficulty writing □ □
History of stroke or transient ischemic attack?_____
Change in ability to speak □ □
Headaches *(circle)* □ □
Frequency: /month
Severity: /10 (10 worst headache of your life)
Quality: throbbing/ shooting
Location: front/back/ a band around the head
Other:_____
Migraines □ □
Frequency: /month
Severity: /10 (10 worst headache of your life)
Quality: throbbing/ shooting
Location: front/back/ a band around the head
Other:_____
History of head injury? □ **No** □ **Yes**
When?
Number of times:
Loss of consciousness? □ **No** □ **Yes**
Other neurological diagnoses:
_____

CARDIOVASCULAR □ NOW □ PAST

Heart palpitations □ □
Heart racing or skipping beats □ □
Murmur □ □

Pain in groin or leg ☐ ☐
Leg cramps ☐ ☐
Varicose veins ☐ ☐
Chest pain ☐ ☐
Sores that won't heal on legs ☐ ☐
Cold extremities ☐ ☐
High cholesterol ☐ ☐
High blood pressure ☐ ☐
Wake up at night with shortness of breath? ☐ ☐
Use pillows to prop you up at night because otherwise you cough or are short of breath?
☐ **No** ☐ **Yes** How many pillows? _____
History of strep throat? ☐ **No** ☐ **Yes**
History of rheumatic fever? ☐ **No** ☐ **Yes**

RESPIRATORY: ☐ NOW ☐ PAST

Shortness of breath at rest ☐ ☐
Shortness of breath with small amounts of exertion. ☐ ☐
How far can you walk before needing to stop?_____
Wheezing ☐ ☐
Pain with taking a deep breath ☐ ☐
Cough
Moist/dry/wet *(circle)*
Spit (sputum) color:
Blood? ☐ **No** ☐ **Yes**

GASTROINTESTINAL ☐ NOW ☐ PAST

Increased appetite ☐ ☐
Decreased appetite ☐ ☐
Abdominal pain ☐ ☐
☐ Better with eating
☐ Worse with eating
Use of NSAIDs ☐ ☐
Acid reflux ☐ ☐
Indigestion ☐ ☐
Bloating ☐ ☐
Gas ☐ ☐
Foul smelling? ☐ **No** ☐ **Yes**
Nausea ☐ ☐
Vomiting ☐ ☐
Diarrhea ☐ ☐
Constipation ☐ ☐
Hemorrhoids ☐ ☐
Hernia ☐ ☐
Fissures ☐ ☐
Parasitic infections ☐ ☐
How many bowel movements a day?_____ easy to pass? ☐ **No** ☐ **Yes**
Diagnosis of IBS ☐ ☐
Diagnosis of SIBO ☐ ☐
Bloody stools ☐ ☐
Black stools ☐ ☐
Undigested food in stools ☐ ☐
Light stools ☐ ☐
Appendicitis ☐ ☐

URINARY ☐ NOW ☐ PAST

Night time urination ☐ ☐
#times:
Incontinence ☐ ☐
Urinary urge without urination ☐ ☐
Inc urgency ☐ ☐
Inc frequency ☐ ☐
Changes in amount of urine ☐ ☐
Cloudy urine ☐ ☐
Changes in number of times you pee ☐ ☐
Incomplete emptying of bladder ☐ ☐
Trickling at the end of urination ☐ ☐
Pain/ burning with urination ☐ ☐
Red urine? ☐ **No** ☐ **Yes** (If yes, did you eat: beets/ pink dragon fruit? ☐ **No** ☐ **Yes**)
Excessive foam in the toilet bowl ☐ ☐
Pain in lower back or sides ☐ ☐
Pain over bladder ☐ ☐

BREASTS ☐ NOW ☐ PAST

Lumps ☐ ☐
Pain ☐ ☐
Tenderness of breast that is not around period ☐ ☐
Nipple discharge ☐ ☐
Inversion of nipple ☐ ☐
Itchy nipple ☐ ☐

Areas of color change	□	□
Breast dimpling	□	□

REPRODUCTIVE	**□ NOW**	**□ PAST**
Loss of sex drive	□	□
Pain with sex	□	□
Genital itching	□	□
Rash	□	□
Discharge changes	□	□
Scars	□	□

Sexual Health Questions

(Both Men and Women)

□ Increase in number of partners, use condoms

□ Increase in number of partners, without condoms

History of sexually transmitted infections?

Which:_____

Types of intercourse you engage in:

Anal/oral /vaginal sex *(circle)*

How do you protect yourself from STI's:

_____

What form of birth control are you using:

_____

Are you trying to conceive?

_____

Females

Hot flashes □ **No** □ **Yes**

First day of your last menstrual period:___/___/____

Cycle length_____ days (day 1 of your period to day 1 of your next period)

Length of menstruation____ days

Painful menstruation: □ **No** □ **Yes** □ **Yes, and I can't do my usual activities on heavy days.**

Flow: □Heavy □Medium □Light

Number of sanitary pads and or tampons on heavy days: Pads:____Tampons:____

Or how many times do you empty your Diva cup on heavy days:_____

Spotting between periods? □ **No** □ **Yes**

Number of pregnancies:_____

Number of births: _____

Number of abortions: _____

Number of miscarriages: _____

Anything else you would like to mention:_____

_____

_____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? ☐ yes ☐ no

Name of adjuster handling claim _____

Will company accept assignment of benefits? ☐ yes ☐ no

If not, will they make checks payable to patient and our office? ☐ yes ☐ no

Limits: How much? $_____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? ☐ yes ☐ no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

_____

_____

_____

_____

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? □ yes □ no

In the event of settlement, will they protect any unpaid balance? □ yes □ no

Do they have PIP? □ yes □ no Do we file? □ yes □ no

Do they have insurance? □ yes □ no Do we file? □ yes □ no

Can we file liability? □ yes □ no

Thank you, please submit your forms to the Front Desk!