COASTAL OSTEOPATHIC *TIMOTHY MANAHAN D.O.*
201 MAIN STREET, SUITE B *WESTBROOK, ME 04092* *TEL: 207-856-7656*

Patient Name_____
(Last, First, Middle)

MAILING ADDRESS_____

_____

TELEPHONE: HOME:_____ **WORK:**_____ **CELL:**_____

DATE OF BIRTH:_____ **AGE:**_____ **SEX: M / F**

SOCIAL SECURITY NUMBER:_____

OCCUPATION:_____ **NAME OF EMPLOYER:**_____

EMPLOYER ADDRESS:_____
EMPLOYMENT STATUS: FULL TIME___ PART TIME___ RETIRED___ STUDENT___

EMERGENCY CONTACT_____ **Parent/Spouse/Significant Other TELEPHONE**_____

PRIMARY CARE PHYSICIAN:_____

ADDRESS:_____ **PHONE**_____

REFERRED BY:_____

HEALTH INSURANCE:
We do not participate with Auto, Liability or Maine Care

Insurance Company_____

Name of Insured:_____ **DOB of Insured**_____

Relationship to Patient_____ **Certificate #**_____ **Group #**_____

COMPLETE ONLY IF THIS IS A WORK RELATED INJURY

DATE OF INJURY:_____ **EMPLOYER AT TIME OF INJURY**_____
ADDRESS:_____ **TELEPHONE:**_____
WORKERS COMPEN INS CO._____
ADDRESS:_____ **TELEPHONE:**_____
CLAIM #_____ **ADJUSTOR:**_____

Many insurance companies have deductibles, co-payments or various restrictions. Please familiarize yourself with your policy as you are responsible for any payments not made by your insurance company.

Referrals and authorizations are your responsibility and must be in place for any appointment with this office

*I herby authorized Dr. Manahan to administer such medical treatmentsas is necessary for the reasons I am counsulting him. *I hereby authorize Dr. Manahan to relaase any information necessary to process claims on my behalf.

_____ _____
(Signature) (Date)

PATIENT NAME: _____ **DOB:** _____

CHIEF COMPLAINT

Where is your pain or problem located? _____

HISTORY OF PRESENT ILLNESS OR PROBLEM

Describe your complaint more fully (i.e., when did it begin; how did it start; any recent episodes; how is it now; other contributing factors). _____

MEDICAL CARE

Whom have you seen for this problem? What did they diagnose, recommend, or treat?

	Practitioner (MD, DO, DC, PT, MT)	Diagnosis/Recommendation/Treatment
1.		
2.		
3.		
4.		
5.		

What tests have been performed and with what results?

1. _____ 3. _____
2. _____ 4. _____

PAIN PERSPECTIVE

On a scale of 0 (no pain) to 10 (agony):

What is your pain level today? _____

What is the lowest it has been? _____

What is the highest it has been? _____

Is it present... ☐ constantly ☐ nearly constantly ☐ occasionally ☐ intermittently

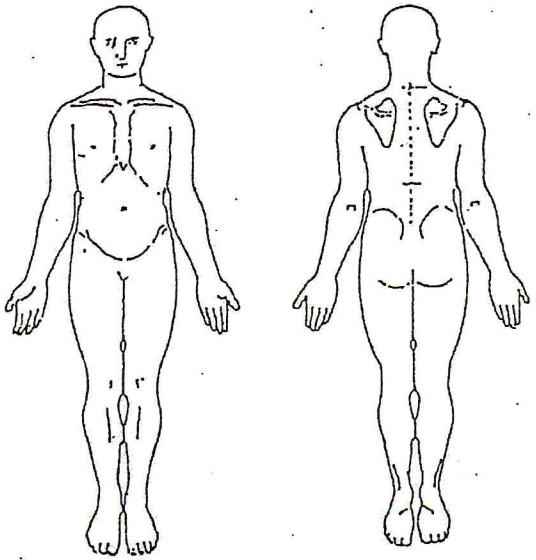
What does it feel like (i.e., sharp, dull, aching, burning, throbbing, radiating, etc.)? _____

What makes the pain worse? _____

What makes the pain better? _____

Mark the problem areas:

X	Sharp pain
O	Dull pain
Δ	Aching pain
⚡	Radiating pain
#	Burning pain
*	Numbness or tingling



FUNCTIONAL STATUS

How does your problem affect your activities at home? _____

How does it affect your activities at work? _____

PATIENT NAME: _____ **DOB:** _____

MEDICATIONS

List all medications (prescription and nonprescription), herbs, remedies, etc. you are now taking.

_____

_____

ALLERGIES & SENSITIVITIES

List all medications to which you are allergic or sensitive.

_____

_____

Other allergies or sensitivities:

_____

REVIEW OF SYSTEMS

Please review the following, and *if significant,* mark any or all as follows:

C = currently applies to me
P = previously applied to me

CONSTITUTIONAL:

___ Appetite problem ___ Chills or fever ___ Low energy
___ Rapid weight gain/loss ___ Poor sleep ___ Weakness ___ Other (explain) _____

HEAD, EARS, NOSE, THROAT, TEETH:

___ Headache ___ Hearing problem ___ Hayfever ___ Infection ___ Throat problem ___ Dental problems
___ Earache ___ Sinus/nasal problem ___ Allergies ___ Tonsils ___ Other _____

EYES:

___ Vision changes or problem ___ Corrective lenses ___ Other _____

CARDIOVASCULAR:

___ Chest pain ___ Blood pressure problem ___ Heart irregularity ___ Stroke ___ Phlebitis ___ Leg cramps
___ Breathing difficulty ___ Swelling hands/feet ___ Heart attack ___ Blood clot ___ Other _____

RESPIRATORY:

___ Cough ___ Bronchitis ___ Shortness of breath
___ Asthma ___ Emphysema ___ Chest infection ___ Other _____

GASTROINTESTINAL:

___ Nausea/vomiting ___ Hiatal hernia ___ Constipation ___ Ulcers
___ Indigestion/heartburn ___ Fat intolerance ___ Diarrhea ___ Blood/stool
___ Abdominal pain/cramps ___ Gallbladder problem ___ Irritable bowel ___ Colitis ___ Other _____

GENITOURINARY:

___ Problems w/urination (frequency or urgency) ___ Blood in urine ___ Prostate problem
___ Urinary tract or other infection ___ Kidney stones ___ Sexual dysfunction ___ Other _____

MUSCULOSKELETAL (other than mentioned in primary complaint):

___ Headache ___ Arm/elbow pain ___ Mid back pain ___ Hip pain ___ Rib pain ___ Arthritis
___ Neck pain ___ Wrist/hand/pain ___ Low back pain ___ Leg/knee pain ___ Fracture ___ Disc problem
___ Shoulder pain ___ Upper back pain ___ Tailbone pain ___ Ankle/foot pain ___ Dislocation ___ Muscle/bone disease
___ Other _____

SKIN, HAIR, BREASTS:

___ Rashes, hives, eczema ___ Skin ulcerations ___ Significant scars ___ Lumps
___ Changes in hair/skin texture ___ Breast problems ___ Bruises ___ Infection ___ Other _____

PATIENT NAME: _____ **DOB:** _____

REVIEW OF SYSTEMS ...CONTINUED

NEUROLOGICAL:

___ Numbness or tingling ___ Arm or leg weakness ___ Concussion ___ Migraine
___ Radiating pain ___ Dizziness ___ Seizure ___ Other _____

PSYCHOLOGICAL:

___ Easily stressed ___ Anxiety ___ Psychological trauma ___ Psychiatric disease
___ Nervousness ___ Depression ___ Phobias ___ Memory loss ___Other _____

ENDOCRINE:

___ Diabetes ___ Excess thirst ___ Hypothyroid ___ Incr./Decr. Metabolism
___ Low blood sugar ___ Excess urination ___ Hyperthyroid ___ Other _____

HEMATOLOGICAL, LYMPHATICS, CANCER, IMMUNE SYSTEM:

___ Anemia ___ Blood disease ___ Chronic infection ___ Cancer (type) _____
___ Swollen lymph nodes ___ Spleen problems ___ Immune system problems ___ Other _____

PREGNANCY & GYNECOLOGICAL:

___ Abnormal periods ___ PMS ___ Menopause (age) ___ Gynecological problems _____
___ Menstrual pain ___ Tubal ligation ___ Number of births ___ Infection ___ Other _____

Are you or could you be pregnant now? ☐ Yes ☐ No

MAJOR ILLNESSES, TRAUMAS, SURGERIES, AND HOSPITALIZATIONS:

List these major occurrences, including approximate dates.

_____
_____
_____

FAMILY MEDICAL HISTORY

List any significant family medical problems.

_____
_____
_____

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widow/widower

How many children? _____

Do you smoke? ☐ Yes ☐ No If yes, specify number of packs per day: _____

Do you consume three or more cups of coffee or caffeinated beverages per day? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How many per week? _____

Have you been under extra stress? ☐ Yes ☐ No Please explain. _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise? _____

Do you sleep well at night? ☐ Yes ☐ No Please explain. _____

What type of work do you do? Job title: _____

Physically, what does this job require (i.e., lifting, bending, sitting, etc.? _____

Have you lost time from work due to your pain problem? ☐ Yes ☐ No How much? _____

At this time are you... ☐ Out of work ☐ Regular duty
☐ Full-time ☐ Light duty
☐ Part-time ☐ Restrictions _____