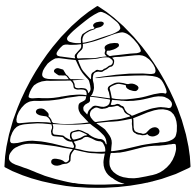


PARAKLETOS
Osteopathic Clinic

4025 St. Cloud Dr. STE 200, Loveland, CO 80538 Dr.Leins@Parakletos.info Ph: (970) 480-0111 Fx: (970) 480-0113

New Patient Form

Name:_____ Date:_____
Date of Birth:_____
Current age:_____

Street:_____
City:_____ State:_____Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Employer:_____

Email:_____

Pharmacy Name:_____ Pharmacy Phone:_____

Emergency Phone:_____ Contact Person:_____

Primary Care Physician:_____
Phone:_____ Address:_____

Referring Physician (if other than primary care physician):_____
Phone:_____ Address:_____

Please Note - Important Information

Prior to your first visit:

- ☐ Please have any relevant imaging reports and/or office notes faxed to our office.
- ☐ If you are filing with your insurance, please contact them to verify coverage and if you will need a referral for services. We do not bill insurance directly at our office, though we will provide you with a document that you may submit to your carrier for reimbursement.

PARAKLETOS Osteopathic Clinic

Reason for Visit:_____

Allergies:_____

Medications: (please include dosage and amount taken per day)

1._____ 7._____
2._____ 8._____
3._____ 9._____
4._____ 10._____
5._____ 11._____
6._____ 12._____

Medical Problems:

1._____ 7._____
2._____ 8._____
3._____ 9._____
4._____ 10._____
5._____ 11._____
6._____ 12._____

Surgeries: (please include dates)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Family History

Father: Living/deceased Age:_____ Health problems:_____
_____
Mother: Living/deceased Age:_____ Health problems:_____
_____
Number of sisters:_____ Health problems:_____
Number of brothers:_____ Health problems:_____

Circle if present in any blood relatives (include parents, grandparents, brothers, sisters, children, cousins, aunts, uncles):

Diabetes	Cancer	High blood pressure	Autoimmune Disease
Heart Disease	Lung Disease	Tuberculosis	Stroke
Epilepsy	Psychiatric Illness	Migraine Headaches	Thyroid Disease
Arthritis	Suicide	Kidney Disease	Liver Disease
Glaucoma	Blood Disease	Alcohol or Drug Abuse	Joint Hyper-mobility

Other inherited conditions:_____

PARAKLETOS Osteopathic Clinic

Social History

Please circle one item that best describes your situation:

Married Divorced
Widowed Single
Living with significant other

Do you have children? Yes No If so, what are their ages?_____

Occupation:_____
Hazardous chemical/environmental exposures?_____

Hobbies:_____
_____

Faith background:_____

Diet: Any dietary restrictions?_____
Typical meals/snacks and mealtimes on an average day:_____
_____
_____
_____

Exercise: (type and frequency)_____
_____

Sleep: Do you sleep well? Yes No
How many hours a night?_____
How many times do you wake up per night?_____
If you have trouble sleeping, what keeps you from sleep?_____

Smoking: Do you smoke? Yes No
If yes, how many packs/day?_____
If used in the past, when did you quit?_____

Alcohol: Do you drink? Yes No
If yes, how many drinks/week?_____
If used in the past, when did you quit?_____

Substances: Recreational drug use? Yes No
If yes, what type and frequency?_____
If used in the past, when did you quit?_____

Coffee/soda/tea:_____How many cups/day?_____

Do you have any pets? (certain pets are linked to specific diseases)_____

PARAKLETOS Osteopathic Clinic

Review of Systems
(please circle any symptoms/conditions you have experienced in the past 12 months)

General:
Weight change
Concerns about weight
Problems with sleep
Fevers
Fatigue
Chills
Weakness
Tremors
Low sex drive
Bruise easily
Dizziness

Cardiovascular:
Chest pain or pressure
Irregular heartbeats
Murmur
Stroke
Heart attack
Poor circulation
Swelling in feet/legs
High blood pressure
Fainting
High cholesterol

Respiratory:
Cough
Wheezing
Short of breath
Pneumonia
Exposure to Tuberculosis

Women:
Date of Last Menstrual period_____
Menstrual problems
Pain
Date of last Pap_____
Concerns about menopause?
Sexually active? Yes No
If yes, with women men both
Method of birth control_____
_____

Breast:
Lumps
Pain
Discharge
Last Mammogram_____

Head, Eyes, Ears, Nose and Throat:
Eye problems
Date of last eye exam_____
Date of last dental exam_____
Dental problems
Seasonal allergies
Ringing in ears
Hearing problems
Earaches
Recurrent sore throat
Sinus problems
Sores in mouth
Nose bleeds
Thyroid problems
Difficulty swallowing
Head injury

Gastrointestinal:
Nausea/Vomiting
Indigestion
Acid reflux/heartburn
Constipation
Diarrhea
Bowel habit changes
Blood in bowel movement
Abdominal pain
Bowel incontinence
Hepatitis

Genitourinary:
Change in urinary frequency
Pain with urination
Sexual problems
Inability to hold urine/leaking
Bladder infections
Kidney infections
Kidney problems
Dialysis

Men:
Pain in genitals
Lumps
Discharges
Hernia
Sexually active? Yes No
If yes, with women men both
Do you use condoms? Yes No

Musculoskeletal:
Joint pain
Joint swelling
Joint redness/warmth
Neck pain
Back pain
Joint injury
Osteoarthritis
Rheumatoid arthritis
Tennis elbow
Carpal tunnel synd.
Bursitis
Muscle spasms

Skin:
Hives
Rashes
Loss of hair
Ulcerations
Itching
Changing moles
Acne
Non-healing sores

Neurologic:
Headache
Blackout/pass-out
Numbness
Tingling
Tremors/shaking
Weakness in arm/leg
Seizure disorder

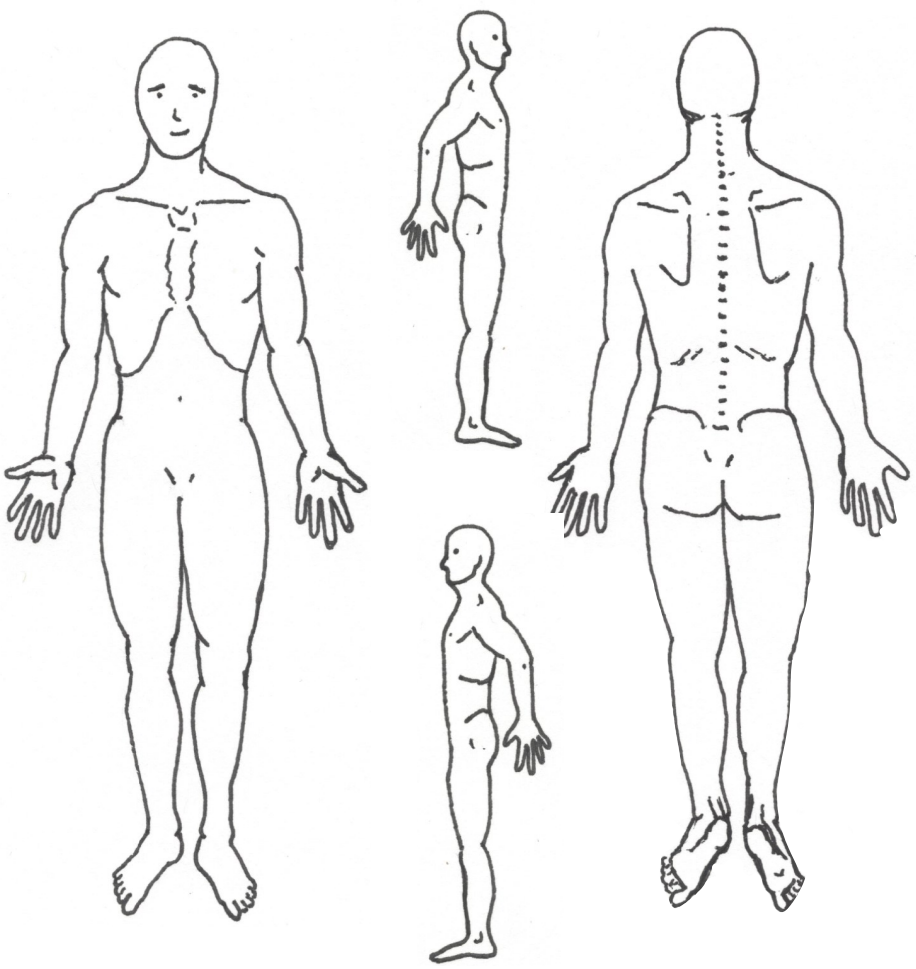
Neuropsychiatric:
Anxiety
Depression
Stress problems
Panic attacks
Poor memory
Recent upsetting-event
Do you feel safe at home? Yes No

Blood:
Anemia
Swollen glands
Concern for HIV/AIDS

PARAKLETOS Osteopathic Clinic

Use this diagram to mark the location and type of pain you are experiencing, shading effected regions and writing the letter that corresponds to your pain beside the region:

N = numbness
P = pins and needles
A = aching pain
S = stabbing pain
B = burning pain



Circle all the following descriptors that apply to your pain:

Throbbing	Shooting	Stabbing	Sharp	Cramping	Gnawing
Hot-burning	Aching	Heavy	Tender	Splitting	Tiring-exhausting
Sickening	Fearful	Punishing-cruel		Other:_____	

Circle all of the following that best describe the pattern of your pain:

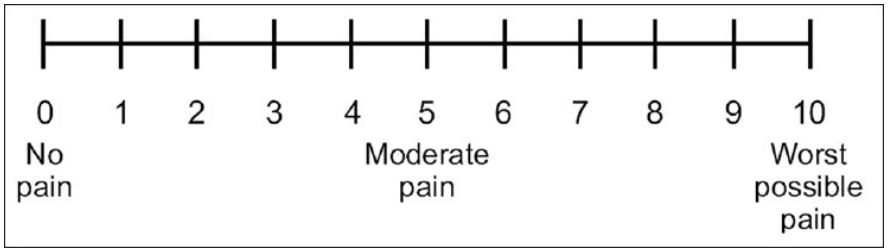
Continuous	Steady	Constant	Rhythmic	Periodic	Intermittent
Brief	Transient	Momentary		Other:_____	

The onset of this pain was: Sudden Gradual

The pain is relieved by:_____

The pain is increased by:_____

PARAKLETOS Osteopathic Clinic



_____Which number (0-10) describes your pain right now?

_____Which number (0-10) describes your pain at its worst?

_____Which number (0-10) describes your pain at its least?

Please circle all of the following physicians or specialists you have consulted
for pain relief for the current problem, not for other problems.

Acupuncturist	General Physician	Osteopathic Physician
Allergist	Hypnotist	Pain Clinic
Anesthesiologist	Internist	Physical Therapist
Chiropractor	Neurologist	Plastic Surgeon
Dentist	Neurosurgeon	Podiatrist
ENT Physician	Nutritionist	Psychiatrist
Endocrinologist	Ophthalmologist	Psychologist
Family Physician	Orthopedic Surgeon	Rheumatologist

Please circle all of the following treatments you have used for pain relief and indicate effect.

	Helped pain	Worsened pain	No change
Massage therapy	_____	_____	_____
Hot packs	_____	_____	_____
Ice	_____	_____	_____
Physical therapy	_____	_____	_____
Chiropractic	_____	_____	_____
Acupuncture	_____	_____	_____
Traction	_____	_____	_____
Brace support	_____	_____	_____
TENS unit	_____	_____	_____
Injection therapy	_____	_____	_____
Oral medications	_____	_____	_____

PARAKLETOS Osteopathic Clinic

HIPAA Patient Consent Form

Patient's Name _____
Date _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.

I hereby give my consent for Parakletos Osteopathic Clinic, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Parakletos Osteopathic Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at Parakletos Osteopathic Clinic, PLLC anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Parakletos Osteopathic Clinic, PLLC, Privacy Officer at 1030 Centre Ave., Suite B, Fort Collins, Colorado 80526, or by accessing it on the website: www.parakletososteopathic.com

With this consent, Parakletos Osteopathic Clinic, PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Parakletos Osteopathic Clinic, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Parakletos Osteopathic Clinic, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Parakletos Osteopathic Clinic, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Parakletos Osteopathic Clinic, PLLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Parakletos Osteopathic Clinic, PLLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Print Name of Patient or Legal Guardian _____