Omaha Health Therapy Center, LLC

Last Name: ______________________________ First Name: _______________________DOB: _____________

Address: ____

Today's Date: __________________________________ Phone Number:_______________________________

Email ____ How did you find us? ____________________

Emergency Contact: ___________________________ Relationship: __________________________________

Emergency Contact Phone #: _________________________________ Marital Status: ____________________

Occupation: _______________________________________ Employer: ________________________________

Are you a Veteran? _____________________________________ If yes, thank you for your service!

Are you a Provider, Nurse, EMT, Firefighter, Police Officer? __________________ If yes, thank you for your dedication to our health/safety!

Please list ALL active treating physicians (i.e. oncologist, pulmonologist, cardiologist, internist, etc.)

Doctor's Name: ____________________________ Specialty: ____________________ Phone #: ______________

Doctor's Name: ____________________________ Specialty: ____________________ Phone # _______________

Primary Care Provider: ____ Phone # _______________________

*****REASON FOR TODAY'S VISIT** ____

General Questionnaire
Have you ever had any of the following: **P = Past (Not in the Past Month) C = Currently (Today or in the past Month)**

Asthma/Breathing Problems……….	☐ P	☐ C
Arthritis………………………………….……	☐ P	☐ C
Bleeding/Clotting Disorder……………	☐ P	☐ C
Blood Pressure Disorder ………………	☐ P	☐ C
Bowel/Stomach Problems ……………	☐ P	☐ C
Cancer……Type _______________…	☐ P	☐ C
Cholesterol Disorder……………………	☐ P	☐ C
Diabetes ……………………………………	☐ P	☐ C
Eye Disorder (i.e. Glaucoma) ……….	☐ P	☐ C
Gynecological/Prostrate Issues ……	☐ P	☐ C
Heart Disease………………………….….	☐ P	☐ C
Lung Disorder………………………….….	☐ P	☐ C
Neurological Disorder…………………	☐ P	☐ C
Chronic Headaches ………………….…	☐ P	☐ C
Psychiatric Disorder/Illness ……….	☐ P	☐ C
Pulmonary Embolism/DVT…………	☐ P	☐ C
Stroke …………………………………….…	☐ P	☐ C
Seizure or Epilepsy ………………….…	☐ P	☐ C
Thyroid Disorder …………………………	☐ P	☐ C
Urinary/Kidney Disorder ……………	☐ P	☐ C

Name: ____ Date: _______________________________

Circle Any Symptoms That Apply To Today's Visit

Constitutional
Chills/Fever
Fatigue
Night Sweats
Unintentional Weight Loss/Gain

Ears/Nose/Throat
Ear Pain
Nose bleeds (frequent)
Nasal Congestion
Runny Nose (frequent)
Hoarseness
Sore Throat

Cardiovascular
Chest Pain
Dizziness
Irregular Heart Beat
Ankle Swelling
Fast Heart Rate
Palpitations

Respiratory
Cough (chronic) (acute)
Difficulty Breathing
Shortness of Breath

Gastrointestinal
Bloating/Abdominal Pain
Difficulty Swallowing
Constipation/Diarrhea
Heartburn/Acid Reflux
Hemorrhoids
Loss of Appetite
Nausea/Vomiting

Genitourinary
Painful Urination
Urinary Incontinence
Nighttime Urination/Excessive Urination
Hx of Frequent Bladder Infections

Musculoskeletal
Painful Joints
Back Pain
Joint Stiffness
Achy Muscles

Integumentary
Acne
Atypical Moles
Dry Skin
Itchy Skin/Rashes

Neurological
Memory Loss
Numbness/Tingling
Dizziness
Fainting
Headaches

Hematologic/Lymphatic
Easy Bruising
Excessive Bleeding
Enlarged Lymph Nodes

Endocrine
Heat/Cold Intolerance
Excessive Thirst/Excessive Hunger
Infertility
Hair Loss

Psychiatric
Feeling Stressed/Anxiety
Depression/Sadness/Crying Spells
Poor Concentration
Sleep Disturbance

Your Blood Type ________________________
Did you receive childhood vaccinations? ______
Are you vaccinated for COVID? _____
If yes, Brand of Vaccine _________

Please List any other medical illnesses or concerns and provide details for any of the above conditions or symptoms:

What interests you about our Clinic? What treatments are you most interested in receiving/learning about?

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/Hospitalization	**Date**	**Complications if any**

Please list any allergies and reactions (i.e. rash, hives, throat swelling, anaphylaxis):

Allergy	**Reaction**	**Allergy**	**Reaction**

Please list all your current Prescriptions:

Medication Name	**Dose**	**Medication Name**	**Dose**

Please list all your current Supplements:

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative **Condition**	**Living?**	**If deceased, at what age?**
	☐ Y ☐ N	
	☐ Y ☐ N	
	☐ Y ☐ N	

Do you currently smoke? ☐Y ☐ N If no, previously? ☐Y ☐ N Years Smoked ______ Packs/day________

Do you use other tobacco products? ☐ Y ☐ N Vape? ☐ Y ☐ N Consume Alcohol? ☐ Y ☐ N If yes, drinks/week_______

If Relevant: Any past pregnancies? ☐ Y ☐ N How Many? ___________ How many deliveries? ________