Napa Valley Osteopathic Medicine
Saskia Lytle-Vieira, D.O.

ADULT NEW PATIENT INFORMATION

Patient Name_____
First Middle Last

Birth Date _____

Address_____

City_____State_____Zip_____

Marital Status (circle) single married partnered widowed

Occupation _____

Please place an * asterisk * by your preferred contact number:

Home Phone_____Mobile Phone_____Work Phone _____

Email_____

Emergency Contact_____Relationship_____Phone_____

How did you hear about us? _____

May we leave messages about your health information via phone? ☐ yes, phone #_____☐no

Have you ever received osteopathic treatment before? no yes if yes, physician's name:_____

Date of last osteopathic treatment: _____

Patient Name: _____

Medical History:
For each issue you want help with, please fill the following table(s). **Please list the issues in order of importance to you**. If you have more than 2 issues you want help with, please copy/print this page or the next page for each new issue as needed.

Issue #1 (example: lower back pain) _____	When did it start? _____	Frequency (ex) *4 times/wk* _____	Severity (ex) *mild/mod/severe* _____
What makes it better? (circle) nothing ice heat rest ibuprofen stretching walking sitting medication massage chiropractic other _____	Did you have a trauma/accident/fall or other notable event occur around the time this problem began?	yes no if yes describe: _____	
What makes it worse? (circle) nothing ice heat rest ibuprofen stretching walking sitting medication massage chiropractic other _____	If the issue causes you physical pain what words would you use to describe the pain? (circle)	nagging dull sharp agony cutting shooting pounding cramping hot burning sore other_____	
What testing or procedures have you had (if any) for this problem? (circle) X ray MRI CT Scan Surgery Ultrasound EMG Injections other_____			
What were results of these tests/procedures: _____ _____ _____ Anything else you want the doctor to know about this problem? _____			

Patient Name:_____

Issue #2	When did it start?	Frequency	Severity _____
What makes it better? (circle) nothing ice heat rest ibuprofen stretching walking sitting medication massage chiropractic other _____	Did you have a trauma/accident/fall or other notable event occur around the time this problem began?	yes no if yes describe: _____	
What makes it worse? (circle) nothing ice heat rest ibuprofen stretching walking sitting medication massage chiropractic other _____	If the issue causes you physical pain what words would you use to describe the pain? (circle)	nagging dull sharp agony cutting shooting pounding cramping hot burning sore other_____	
What testing or procedures have you had (if any) for this problem? (circle) X ray MRI CT Scan Surgery Ultrasound EMG Injections other_____			
What were results of these tests/procedures: _____ _____ _____ Anything else you want the doctor to know about this problem? _____ _____ _____ _____			

Patient Name:_____

Have you seen a specialist for the problem(s)? (*Ex:, pain management doctor, neurologist, GI doctor*) yes no

If yes, what was diagnosis/treatment plan?

_____
_____
_____
_____

What do you hope to get from treatment? (*Ex: "I want to be able to walk for 15 minutes daily without back pain")*

_____
_____
_____
_____

What medical conditions do you have now or in the past? (please circle)

Abnormal Heart Rhythm	Bleeding Disorder	Eye Problems	Migraines
Acid Reflux/Heartburn	Blood Clots	Glaucoma	Pacemaker
AIDS/HIV	Breast Cancer	Heart Attack	Joint Replacement
Alcoholism	Cancer _____	Heart Problem	Pneumonia
Allergies	Colon Cancer	Hepatitis	Prostate Cancer
Alzheimer's	COPD	High Blood Pressure	Skin Problem
Anemia	Constipation	High Cholesterol	Stroke
Arthritis	Chronic Diarrhea	Irritable Bowel Syn.	TIA (mini stroke)
Asthma	Drug Dependence	Kidney Problem	Thyroid Problem
Anxiety	Depression	Liver Problem	Tuberculosis
Birth Defects	Diabetes	Lung Disease	Ulcers
Breast Problem	Epilepsy/Seizures	Mental Illness	Vertigo

Other_____
_____

This section for women only:

Are you currently pregnant? no yes if yes, how many weeks? _____
Have you ever been pregnant? no yes if yes, how many times? _____
Did you give birth: vaginally c-section

Patient Name:_____

Have you had any hospitalizations or surgery of **any kind** (including cosmetic)?

What	*When*	*What*	*When*

Have you had any car accidents of **any kind**?

Year?	*Driver or passenger?*	*Where was car hit?*	*Speed of crash?*	*Your injuries?*	*Did airbag go off?*
1.					
2.					
3.					
4.					
5.					

Dental History: please circle

Tooth extractions? yes no # teeth out____ Root Canals? yes no

Dentures? yes no

Orthodontia? (braces, retainer) yes no Dental surgery? yes no

Do you use a night guard/bite plate? yes no top or bottom teeth?

Birth History: please circle

Were you exposed to alcohol, tobacco, or other drugs while your mother was pregnant with you? yes no

Were you born vaginally c-section

Were you born premature? yes no if yes, how many weeks early at birth? _____

Were you breast fed bottle fed both

Patient Name_____

Have you ever been told you almost died at birth or were very ill in infancy? yes no if yes, please explain_____

Have you ever:
Broken any bones? yes no which bone(s)?
_____

Had any head trauma? yes no
explain:_____

Any other injuries/accidents not already mentioned on this form: _____
_____
_____

Have you ever been told you have one leg shorter/longer than the other?
yes no if yes L or R

Have you ever been told you have scoliosis? yes no

Please list any prescription medications that you are **currently taking**:

Medication *Ex. Lipitor*	Reason *High cholesterol*	Year started *1999*	Dosage *10mg once daily*

Do you have any allergic reactions to medications?

Medication	Reaction/ Intolerance

Patient Name: _____

Please list any supplements, vitamins, or herbs you are **currently taking:**

Brand and name (manufacturer) *Ex. Siberian ginseng*	Reason *Energy*	Year Started *2001*	Dosage *500mg twice daily*

Family History: *If any blood relative has suffered any of the following, please indicate which relative.*

Allergies_____Asthma_____Anemia_____Arthritis_____Alcoholism_____
Blood Disorder_____Cancer_____Diabetes_____Epilepsy_____
Glaucoma_____Genetic Disease_____Gout_____Headaches_____
Heart Attack_____High Blood Pressure_____Kidney Problem_____
Liver Problem_____Mental Illness_____Neurological Problem_____ Stroke
_____Tuberculosis_____ Other _____

Your habits/lifestyle: (check the box)

Tobacco? ☐ never ☐ currently ☐ in the past _____packs/day
Alcohol? ☐ never ☐ currently ☐ in the past # drinks/ day _____
Other drugs? ☐ never ☐ currently ☐ in the past type and frequency
_____

Do you exercise regularly? yes no
Do you enjoy your job? yes no
How many hours do you sleep each night? _____
Do you dream at night? yes, frequently yes, occasionally yes, but rarely no

Typical breakfast:_____

Typical lunch:_____

Typical dinner:_____

Snacks:_____

Patient Name:_____

Activity at work: (please circle)

Sitting moderately active heavy lifting computer work # of hours /day on computer _____

Are you on the phone more than 15 minutes daily at work? yes no

If yes, do you have a headset? yes no if yes, do you use it? yes no

Review of Symptoms: please circle any symptoms that **currently** apply to you:

Constitutional: poor appetite fevers chills weight loss weight gain fatigue

Ears, Nose, Mouth, Throat: headaches jaw clicking teeth problems grinding teeth chewing problems facial pain sore throat mouth sores bad breath ringing in ears nosebleeds postnasal drip sinus problems trouble with taste/smell hearing problems earaches other: _____

Muscles, Bones, and Joints: neck pain back pain muscle pain painful joints joint swelling muscle weakness muscle cramps numbness tingling other: _____

Digestion & Intestine: indigestion belching swallowing problem heartburn (GERD) liver problems diarrhea abdominal cramping gas constipation abdominal pain rectal pain hemorrhoids blood in stool black stools change in bowel habits nausea vomiting other: _____

Eyes: eye pain blurry vision wear glasses/contacts poor day/night vision other:_____

Heart and Circulation: chest pain heart murmur lightheadedness palpitations cold hands/feet fainting swelling in feet or ankles blood clots varicose veins other:_____

Breathing and Lungs: shortness of breath wheezing/asthma COPD frequent colds/flu cough other: _____

Skin, Hair, Breasts (men and women): breast lumps or pain breast leaking fluid skin rashes itching/hives hair loss dry skin/eczema other: _____

Nerves, Movement, Brain: seizures nerve pain balance problem tremors/shaking numbness other: _____

Urine, Kidney, Bladder: painful urination waking up a lot to urinate kidney stones trouble controlling urine frequent urination blood/pus in urine frequent urinary tract infections other: _____

Immune System: frequent infections environmental sensitivity other: _____

Blood: swollen lymph glands anemia easy bruising other:_____

Psychological well being: anxiety depression hospitalization for psychiatric issue other: _____

Reproductive System: genital sores lumps/swelling painful intercourse infertility other:_____

Women's Reproductive System: pelvic pain vaginal discharge painful periods PMS hot flashes itching other: _____

With whom do you live? *(Include roommates, friends, partner, spouse, children, parents, relatives, and pets.)*

Name	Age	Relationship	Name	Age	Relationship

Is there anything else you want the doctor to know?

_____

_____

_____

Please read the following and sign at the bottom:

I am requesting osteopathic consultation and treatment from Saskia Lytle-Vieira, D.O. I understand that Dr. Lytle-Vieira is a board certified physician specializing in osteopathic manipulative medicine/neuromusculoskeletal medicine. I understand that while she is fully licensed to practice medicine in the state of California, Dr. Lytle-Vieira's practice is a specialty practice devoted to consultations for osteopathic manipulative treatment in the management of the full spectrum of a patient's healthcare needs. I understand that her practice does not include the primary management of medical conditions of a chronic nature, routine blood work, "screening"/checkups, or the prescription or supervision of long term chronic medications. I understand that Dr. Lytle-Vieira is not on call and does not admit patients to the hospital. I understand that Dr. Lytle-Vieira is not a primary care physician, and I agree to have my own primary care physician for my ongoing healthcare needs, routine checkups, blood work, and long-term medication prescription management. By signing below, I state that I understand the above and agree to its terms.

_____ _____

Signature of patient Date