OAA
Orthopaedic Specialists

250 Cetronia Rd.
Allentown, PA

1241 Blakeslee Blvd. Dr. E
Lehighton, PA 18235

2901 Emrick Blvd.
Bethlehem, PA 18021

phone: 610-973-6200 | www.oaaortho.com | fax: 866-644-0894

HEALTH EVALUATION PROFILE

NAME: _____ **AGE**: _____ **BIRTHDATE**: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

PHONE NO: _____ **FAMILY PHYSICIAN**: _____ **REFERRED BY**: _____

WEIGHT: _____ **HEIGHT**: _____ **PROFESSION**_____ **E-MAIL**_____

REASON FOR SEEKING THIS CONSULTATION:

_____

_____

_____

If you are currently take vitamins or other supplements, please list them here, or attach your own list. **Please bring all supplements that you are currently taking to your first appointment.**

_____

_____

_____

MEDICATIONS/CONDITIONS: Please check any of the following medications that you are currently taking.

□ Antacids
□ Antibiotics
□ Antidepressants
□ Anti-Inflammatory Medication
□ Laxatives
□ Water Retention
□ Heart Medication
□ Blood Pressure Medication
□ Hormones
□ Ulcer Medications
□ Oral Contraceptives
□ Radiation and/or Chemotherapy
□ Thyroid Medication
□ Steroids (ie: Prednisone)
□ _____

How did you learn about this Practice?

□ Friend □ Physician/Office Referral _____

□ Yellow Pages □ Advertisement

MEDICAL HISTORY

	Yourself	Mother	Father	Siblings	Grandparents
Alcoholism/Drug Abuse					
Allergies					
Alzheimer's					
Arthritis (Osteo or Rheum.)					
Cancer (type)					
Circulatory Problems					
Diabetes (Type I or II)					
GI Intestinal Disease (type)					
Hearing Problems					
Heart Disease					
High Blood Pressure					
Hormone Difficulties					
Infertility					
Kidney Disease					
Mental Illness					
Musculoskeletal Disease					
Nervous System Problems					
Osteoporosis					
Respiratory Problems					
Sexually Transmitted Disease					
Thyroid Problems					
Tumors (benign or cancer)					
Vision problems					
Other _____					

Do you have any pets? _____

Please list any medications you are currently taking, the reason you are taking them, and their doses.

Medication _____ Reason: _____ Dose: _____

Medication _____ Reason: _____ Dose: _____

Medication _____ Reason: _____ Dose: _____

Medication _____ Reason: _____ Dose: _____

Metabolic Screening Questionnaire

Client Name _____ Date _____ Visit _____

Rate each of the following symptoms based upon your typical health profile for: ***Past 30 days***

POINT SCALE:
0 = *Never or almost never* have the symptom
1 = *Occasionally* have it, effect is *not severe*
2 = *Occasionally* have it, effect is *severe*
3 = *Frequently* have it, effect is *not severe*
4 = *Frequently* have it, effect is *severe*

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **Total** _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(does not include near- or far-sightedness) **Total** _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total** _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Excessive mucus formation **Total** _____

MOUTH/THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Canker sores **Total** _____

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total** _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total** _____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal / Stomach pain **Total** _____

JOINT/MUSCLE

_____ Pain or aches in joint
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness

	_____ Depression	**Total** _____
MIND	**_____** Poor memory	
	_____ Confusion, poor comprehension	
	_____ Poor concentration	
	_____ Poor physical coordination	
	_____ Difficulty in making decisions	
	_____ Stuttering or stammering	
	_____ Slurred speech	
	_____ Learning disabilities	**Total** ____
OTHER	**_____** Frequent illness	
	_____ Frequent or urgent urination	
	_____ Genital itch or discharge	**Total** _____
GRAND TOTAL		***TOTAL*** **_____**

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PAST MEDICAL HISTORY INFORMATION

Please answer the following questions as completely as possible and also supply any other pertinent information you feel is necessary. If you need to supply additional information, please use the back of this form.

Age 0-10: Were you born of a normal pregnancy and delivery? _____
Were you fully vaccinated? _____ Were there any complications? _____
Did you have the normal childhood diseases? _____ Were there any complications? _____
Were you a healthy child? _____ If not, please explain: _____
_____

If you are seeking counseling for a specific problem, did your symptoms first occur during childhood? _____ At what age? _____
Did you experience any trauma or hospitalizations during this time?
_____
Did anything else significant occur to you during this decade? _____
_____

Age 10-20: If you are a woman, at what age did menstruation begin? _____
Did/Have you experienced any hormonal difficulties? If so, please explain:
_____
_____
_____

If you are a man, at what age did puberty begin? _____
Did use alcohol, drugs or tobacco? _____
Did you have any sexually transmitted diseases? _____
If you are seeking counseling for a specific problem, did your symptoms first occur during this decade? ____ If so, at what age? ____
Did you experience any trauma or hospitalizations during this time? _____
_____
If you are a woman, did you have any pregnancies during this decade? _____
If yes, was the pregnancy full-term and free of complications: _____
If no, please explain: _____
Did anything else significant occur to you during this decade? _____
_____

Age 20-30: Did you have any children/pregnancies? _____
If yes, how many? _____ Were they full-term? _____
Were the pregnancies free of complications? _____
If there were complications, please explain: _____
_____
Do/Did you use birth control medication? ____ If so, for how long? _____
Did you have any surgeries? _____ If yes, please explain: _____
Did you experience any trauma/accidents during this decade? _____
If yes, please explain: _____

For the following decades, please provide similar information as asked above, if applicable. If possible, please indicate the year you are discussing, or your age at the time. If you don't know if something is significant, write it down anyway, as we may find this information useful. Be as thorough as possible, but don't burden yourself to explain everything in its entirety. We will be discussing this information during your visit, so full explanations can be discussed at that time. If you have experienced any problems with PMS, menopause, prostate problems, or osteoporosis, or have used are or are using hormone replacement therapy, please indicate this below.

Age 30-40:

Age 40-50:

Age 50-60:

Age 60-70:

Age 70-Present:

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RELEASE FORM
PLEASE READ CAREFULLY

I understand that according to the Federal Food, Drug & Cosmetic Act, as amended Section 201 (G)(1), the term "DRUG" is defined to mean: Articles intended for the use in the DIAGNOIS, CURE, MITIGATION, TREATMENT or PREVENTION of disease. In other words, to "say" that a vitamin, mineral, trace element, amino acid or enzyme will have any effect on disease or symptoms thereof, that particular nutrient then becomes a DRUG under the law as written, Therefore, be advised that the suggested nutritional program is not intended as primary therapy for any disease or symptom, but is an adjunctive schedule of nutrients (food concentrates) provided solely to upgrade the quality of foods in the diet in order to supply good nutrition for supporting the physiological and biochemical processes of the human body.

I further understand that all recommendations for supplementation by the practitioner are to be followed at my discretion.

By my signature below, I agree to the terms above:

_____ _____

Signature Date

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FOOD DIARY

(Please complete for 4 days)

DAY 1

Breakfast _____
Mid Morning Snack_____
Lunch_____
Mid Afternoon snack_____
Dinner_____
After Dinner_____

DAY 2

Breakfast _____
Mid Morning snack_____
Lunch_____
Mid Afternoon snack_____
Dinner_____
After Dinner_____

DAY 3

Breakfast _____
Mid Morning snack_____
Lunch_____
Mid Afternoon snack_____
Dinner_____
After Dinner_____

DAY 4

Breakfast _____

Mid Morning snack_____

Lunch_____

Mid Afternoon snack_____

Dinner_____

After Dinner_____

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Cancellation Policy

Frequent cancellations cause multiple issues for any practice, and ours is no exception. While we understand an occasional need to cancel an appointment due to illness or an emergency, constant cancellations result in appointment times that cannot be offered to others, as well as another future date being filled, which further limits times for us to make available. When a client cancels 2 consecutive appointments, a credit card will be requested to keep on file before we will schedule a third time. Additionally, if a client shows a persistent habit of cancelling appointments, we will be forced to discontinue our services to that individual. We are increasingly being asked why it takes so long to get an appointment. Unfortunately, we cannot predict who will honor their appointment times in advance. Please bear in mind that if you cancel, that appointment time could have been made available to someone else. Your consideration will be greatly appreciated.

I have read and understand the above, and will do my utmost to keep my scheduled appointment time, as well as those in the future. If I am not able to consistently keep my appointments, I understand that OAA Orthopaedic Specialists has the right to discontinue making their services available to me.

Name_____ Date_____