CENTER FOR
OROFACIAL MYOLOGY
208.793.7006 | 8601 W. Emerald St Suite 150 Boise, ID 83704 | frontdesk@boiseshc.com

Adult Intake Forms Current Date:___/___/___

Patient Information:

Legal name:_____ Nickname:_____ DOB:_____
Street Address _____ City:_____ State:___ Zip_____
Social Security Number: _____ E-mail: _____
Home phone _____ Work phone_____ Cell phone _____
Cell phone provider: _____
Age:_____ Sex: male female
Marital Status: married single divorced separated widowed
Primary Care Physician:_____ Referring Physician:_____
Spouse Name: _____ Phone: _____
Preferred pharmacy:_____
How did you hear about us? _____

Insurance Information:

Primary insurance company:_____ Phone:_____
Subscriber name: _____ Relationship: _____
Subscriber DOB:_____ ID#_____ Group #_____
Secondary insurance company:_____ Phone:_____
Subscriber name: _____ Relationship: _____
Subscriber DOB:_____ ID#_____ Group #_____

Patient Questionnaire:

Height_____ Weight:_____
CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?_____
2. How long have you had this problem?_____
3. How severe is this problem? (Circle) 1 2 3 4 5 6 7 8 9 10
   Mild very severe
4. How often does this problem occur? constant comes and goes
5. What makes it better? _____
6. What makes it worse?_____
7. What other symptoms are you having?_____

PAST MEDICAL HISTORY (Please check all symptoms you have):

□ High blood pressure □ Asthma/Emphysema □ Rheumatic Fever
□ Kidney disease □ Stroke/mini-stroke □ Sinusitis
□ Diabetes □ Heart disease/Angina □ Peptic Ulcers
□ Neck/Back disease □ Hepatitis/Liver disease □ Thyroid disease
□ Cancer (please list type and date diagnosed): _____
Other:_____
_____

PAST SURGICAL HISTORY (please check all surgeries you have had):
□ Heart bypass/valve □ Gall bladder □ Prostate removal
□ Coronary angioplasty □ Lung surgery □ Colon removal
□ Carotid artery surgery □ Joint replacement □ Appendix removal
□ Vascular bypass □ Back surgery □ Sinus surgery
□ Mastectomy □ Brain surgery □ Tonsillectomy
□ Heart transplant □ Liver transplant □ Kidney transplant
Other
_____
_____

MEDICATIONS (List all your current medications and the dose you take):
Medication:_____ Dose: _____
Medication:_____ Dose: _____
Medication:_____ Dose: _____
Medication:_____ Dose:_____
Do you take Aspirin or Ibuprofen? □ Yes □ No
Do you take Warfarin (Corumadin)? □ Yes □ No

ALLERGIES (circle all that apply)
None Dust Pollen Moldy places Cut grass Animals Food

Smoke/Fumes Outside in spring/fall Air Conditioning Outside on Windy Day

Latex Iodine Tape Contrast agents(Dye)

Other allergies/Problems not listed :
_____
_____

FAMILY HISTORY (check all illnesses that run in your family):
□ Hearing loss □ Alcoholism □ Heart Attack
□ High blood pressure □ Psychiatric illness □ Cancer
□ Sickle cell anemia □ Bleeding problems □ Diabetes
□ Poor circulation □ Anesthesia reaction □ Stroke

Others:_____
SOCIAL HISTORY:
How many children do you have? _____
Have you ever smoked? □ Yes □ No (□ cigarettes, □ cigar, □ pipe)
How much, and for how long have you smoked? _____ packs per day for ___years
How much alcohol do you drink each day? _____
List any street drugs you currently use: _____
Do you have any drug addictions? □ Yes □ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past)

CONSTITUTIONAL

□ weight loss_____pounds in the past _____weeks □ fever/chills

EYES

□ Double Vision
□ Loss of Vision
□ Eye pain

ENT:

□ Hearing loss □ Nose Drainage □ swallowing pain
□ Ringing in ears □ Nasal Congestion □ voice change
□ Dizziness □ Facial Pain □ snoring
□ Ear pain □ Headaches □ Hoarseness
□ Ear drainage □ Sore mouth/throat □ poor sleep

CARDIOVASCULAR/PULMONARY

□ Chest pain □ Heart attack □ irregular heartbeat
□ Poor circulation □ Leg pain during walking □ coughing up blood
□ Shortness of breath □ Asthma

GASTROINTESTINAL

□ Stomach ulcers □ Nausea/vomiting □ Diarrhea
□ Blood in stool □ Trouble swallowing □ Abdominal pain

GENITOURINARY

□ Blood in urine □ Pain during urination □ Difficulty making urine

MUSCULOSKELETAL

□ Neck/spine surgery □ Neck of Back Disorder □ Arthritis

NEUROLOGICAL

□ Stroke □ Ministroke □ Loss of sensation
□ Temporary loss of vision or speech control □ Facial paralysis
□ Paralysis of an arm or leg

SKIN

□ Skin cancers □ allergy to medical tape, iodine, or latex

PSYCHIATRIC

□ Clinical depression □ Schizophrenia □ Anxiety
□ Hallucinations □ Other psychiatric disorder (list)_____

INFECTIOUS DISEASE

□ Hepatitis □ HIV/AIDS □ Mononucleosis
□ TB

I have personally reviewed this history and review of systems:

_____ _____
Attending Signature Date

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EVALUATION RESERVATION POLICY

The Center for Orofacial Myology strives to maximize each patient's potential. Careful planning and time goes into preparing for an evaluation. There is a waiting list for current evaluation slots.

Please be advised that when booking your evaluation appointment we will ask for your credit/debit card number and you will be charged a deposit of ***$50 (fifty dollars)*** *to hold your time slot. After you complete your scheduled evaluation and we bill your insurance, this deposit will be used towards your patient balance or any future sessions. If your insurance covers 100% of your evaluation and session charges, the deposit will be refunded to you after we receive your insurance payment.*

If you must reschedule your evaluation appointment, you must do so at least ***48 hours*** *(two days) before your appointment. The fee for less than 48 hours notice is* ***$50 (fifty dollars)****,* ***a full forfeiture of your deposit****.*

If you cancel your evaluation appointment and choose not to reschedule, ***your credit/debit card will be charged $250 (two hundred fifty dollars).***

If you fail to show up for your scheduled evaluation and have not given us any notice, ***your credit/debit card will be charged $250 (two hundred fifty dollars)****.*

I hereby authorize Chatterton Speech Therapy (doing business as Center for Orofacial Myology) to charge my credit/debit card in the amount of $50 to hold my time slot and agree to the terms and conditions explained above.

_____

Signature *Date*