Deborah Pyne, D.O.

Patient Information

Adolescent Intake Forms (12-17 years)

3242 Preston Road,
Suite 203
Plano, Texas 75093

(972) 733-1955
fax (972) 733-1990

drdebpyne.com
info@drdebpyne.com

Patient Checklist

We are pleased that you have chosen Deborah Pyne, D.O. to consult in your medical care. She will be working with you to help you understand your present condition and help achieve your intentions for improved health.

We ask that you complete and return this packet along with any additional paperwork before you come for your first appointment. You can email the completed forms, fax them to 972-733-1990, upload them here, or drop them off in person.

- [ ] Complete the enclosed forms in their entirety.
- [ ] Collect any relevant test results, x-rays/MRI reports and records. See page 9 for a medical records request form.
- [ ] Make a list of your symptoms and a timeline of these symptoms.
- [ ] Spend a few minutes thinking about your goal for the visit and write down any questions you want answered.
- [ ] Bring your medications and supplements in addition to the written list located on page 12.
- [ ] If you are coming for a musculoskeletal-related problem, wear soft, stretchy clothing like yoga pants or sweat pants.
- [ ] We ask that anyone over the age of 2 who enters the facility wear a mask. KN95 masks are available upon request.
- [ ] If a guardian is not accompanying you to your appointment, authorization must be provided to allow treatment and approval is required from Dr. Pyne. See page 10 for a consent for treatment form.
- [ ] Please help us maintain a fragrance free atmosphere for our chemically sensitive patients by avoiding cologne, perfume, and scented body products as much as possible on the day of your appointment.

Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____

I authorize Name/Title: _____

Address: _____

_____

Telephone: _____ Fax: _____

To release my health information to:

Deborah Pyne, D.O.
3242 Preston Road, Suite 203
Plano, Texas 75093
T: 972-733-1955 F: 972-733-1990

Type of Information: **please send anything over 10 pages by mail**

- ☐ Complete Medical Records
- ☐ Lab Results Only
- ☐ Progress Notes Only
- ☐ Other _____

Notice: We are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: This authorization to release health information is voluntary. This authorization may be revoked at anytime. The revocation must be in writing, signed by you or your representative. You are entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of you signing the form.

Name (parent or legal guardian) Signature Date

Consent For Treatment

I give permission for my child _____ to be medically evaluated and treated by Deborah Pyne, D.O. in my absence. I understand that it may be necessary to perform diagnostic test in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:

- physician evaluation and consultation
- osteopathic manipulation
- prescriptions and treatment
- laboratory, scoliosis and blood pressure screening
- first aid and emergency care
- referrals to an outside agency for services not provided at the office

If there are any services that you do not consent to in your absence, please list:

_____

_____

☐ My child will be accompanied by:

☐ himself/herself

☐ family member (name): _____

☐ other (name): _____

I give permission for Deborah Pyne, D.O. to share any relevant health information with the person who is accompanying my child.

Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of you signing the form.

_____

Name (parent or legal guardian) Signature Date

General Information

Who is completing the forms? ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other Relative ☐ Other ☐ Patient			**Name if other than patient:**
Patient Last Name: **First:** **Middle:**			**Preferred Name:**
Birth Date:	**Age:**	**Sex:** ☐ M ☐ F ☐ Other	**Parent or Legal Guardian Mobile Phone:** ✓ if we may leave messages on this line ☐
Address:			**Patient Mobile Phone:** ✓ if we may leave messages on this line ☐
City: **Zip Code:**			**Home Phone:** ✓ if we may leave messages on this line ☐
Name of all Parents or Legal Guardians:			**Parent or Legal Guardian Work Phone:** ✓ if we may leave messages on this line ☐
How did you hear about our office?			**Parent or Legal Guardian Email Address:** ✓ if you have read the informed consent ☐
Pharmacy: **Phone:**			**Patient Email Address:** ✓ if you have read the informed consent ☐
Emergency Contact: **Relationship:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			
Primary Care Physician: **Address:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			
Other Contact: **Relationship:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			

Name Signature Date

Health History

Patient Name: | **Birth Date:**

List your desired goals by priority:

List current and ongoing conditions or problems:

Weight: | **Height:**

Date & location of last physical:

Illnesses You've Had:

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer

☐ Chickenpox ☐ COVID-19 ☐ Depression

☐ Diabetes ☐ Glaucoma ☐ Epilepsy

☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure

☐ Kidney Disease ☐ Measles ☐ Mumps

☐ Rheumatic Fever ☐ Rubella ☐ Polio ☐ STD

☐ TB ☐ Thyroid Disease ☐ Ulcer/Reflux ☐_____

Immunizations and most recent date:

☐ COVID-19 _____

☐ Hepatitis A _____ ☐ Hepatitis B _____

☐ Influenza (Flu) _____

☐ HPV _____

☐ Tdap (Tetanus, Diphtheria, Pertussis) _____

☐ MMR (Measles, Mumps, Rubella) _____

☐ Meningococcal _____

☐ Pneumococcal _____

☐ Varicella (Chickenpox) _____

☐ Zoster (Shingles) _____

Allergies (Medications, Food, Environment):

Medication List (include prescribed drugs, over-the-counter medications, vitamins and supplements):

Medication:	Strength:	Dosing:	Medication:	Strength:	Dosing:

List all family members' significant health problems. Include age the problem first occurred:

Mother:

Father:

Sibling:

Sibling:

List past surgeries and hospitalizations:

Incident:	Date:	Reason:	Comments:

List injuries or physical trauma you have experienced that may be related to pain:

Injury/Trauma:	Date:	Comments:

Have you undergone any of the following diagnostic studies? Include the date:

☐ Allergy Testing _____ ☐ Echocardiogram _____ ☐ EKG _____

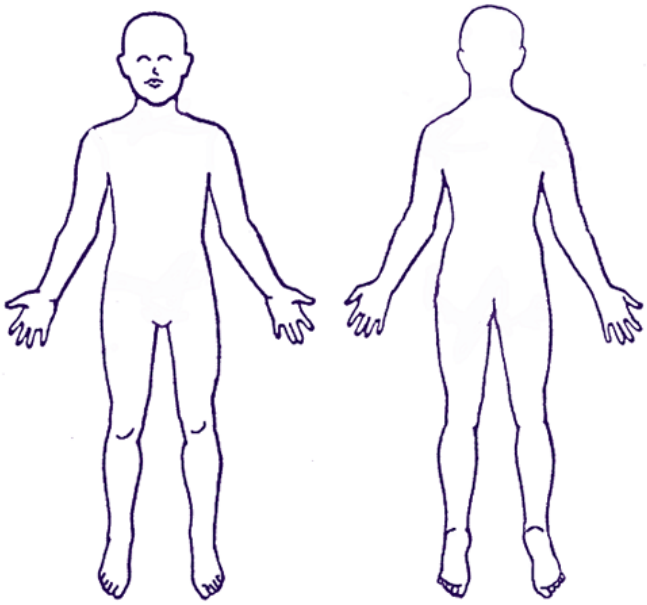
☐ Hearing Screening _____ ☐ Vision Screening _____

☐ CT Scan _____ Part of Body: _____ ☐ X-Ray _____ Part of Body: _____

☐ Ultrasound _____ Part of Body: _____ ☐ MRI _____ Part of Body: _____

Mark specific areas of pain with the following ratings:

1 - mild 2 - moderate 3 - severe



Do you experience numbness or tingling? ☐ Yes ☐ No

Where?

Do you experience any of the following?

☐ Joint Pain ☐ Joint Stiffness ☐ Joint Soreness

☐ Joint Redness ☐ Joint Heat ☐ Joint Swelling

Where?

Do you have any specific joint limitations? ☐ Yes ☐ No

Where?

Do you experience morning stiffness? ☐ Yes ☐ No

Lasts for _____ hour(s)

Do you have any lack of flexibility? ☐ Yes ☐ No

Where?

List any specific activities that cause you pain:

List any treatments you have tried and their outcome:

How do you FEEL about the following areas of your life?

Self: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Family: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Friends: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

School: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Eating Habits: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Activities: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Spirituality ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Please rate your daily energy levels:

☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

How many hours do you sleep at night?

Please rate your energy levels after exercise:

☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

Do you fall asleep within 15 minutes?

Please rate your stress levels:

☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

Do you sleep through the night?

Do you feel worse at certain times of year?

☐ Spring ☐ Summer ☐ Fall ☐ Winter

Do you wake feeling rested?

What are your hobbies and leisure activities?		**What kind of exercises do you do?** ☐ Jogging/Walking ☐ Weight Training ☐ Golf ☐ Cardio Machines ☐ Aerobics ☐ Pilates ☐ Tennis ☐ Yoga ☐ Other:	
Do you exercise regularly? ☐ Yes ☐ No	**How many times a week?** ☐ 1 ☐ 2 ☐ 3 ☐ 4+		
Over the past 6 months, have you felt down, depressed or hopeless for more than 2 weeks at a time? ☐ Yes ☐ No		**Over the past 6 months, have you felt little interest doing things for more than 2 weeks at a time?** ☐ Yes ☐ No	
Do you drink caffeine?: ☐ Yes ☐ No # of cups per day:		**Do/did you smoke?** ☐ Yes ☐ No # of years_____ #Packs_____ Year quit_____	
Do you drink alcohol? ☐ Yes ☐ No # of drinks per week_____		**Have you ever been exposed to toxic chemicals or metals?**	
Do you experience any symptoms immediately after eating certain foods, such as belching, bloating, sneezing, or hives?			
Do you experience any delayed symptoms after eating, certain foods (24 hours+) such as fatigue, muscle aches, or sinus congestion?			
Do you feel worse after eating or drinking any of the following? ☐ High Fat Foods ☐ High Protein Foods ☐ Carbohydrates ☐ Sugar/Junk Foods ☐ Alcohol			
Do you ever experience gas? ☐ Often ☐ Occasionally ☐ Rarely		**Are you on a special diet?**	
How often to you typically have a bowel movement? ☐ More than 3 times a day ☐ 1-3 times a day ☐ 4-6 times a week ☐ 2-3 times a week ☐ 1 or less times a week			
How would you describe your bowel movements? ☐ Soft and well formed ☐ Often floats ☐ Difficult to pass ☐ Diarrhea ☐ Thin, long and narrow ☐ Small and hard ☐ Loose but not watery ☐ Alternating loose/hard ☐ Greasy or shiny ☐ Brown ☐ Yellow or light brown ☐ Color Varies ☐ Dark or black ☐ Greenish			
How often have you taken antibiotics?: ☐ less than 5 times ☐ more than 5 times		**How often have you taken oral steroids?:** ☐ less than 5 times ☐ more than 5 times	
Have you noticed any of the following changes to your hair? ☐ Dryness ☐ Brittle ☐ Change in texture ☐ Thinning ☐ Hair loss ☐ Other_____			
Have you noticed any of the following changes to your skin? ☐ Dryness ☐ Redness ☐ Rash ☐ Oily ☐ Acne/Breakouts ☐ Other_____			
Women Only			
Last OB/GYN exam:	**Last mammogram:**	**Last menstrual period:**	**Age of first menstrual period:**
Length of menstrual periods:	**Do you experience any of the following during your cycle?** ☐ Heavy Flow ☐ Irregularity ☐ Spotting ☐ Pain ☐ Discharge		
Number of pregnancies:	**Number of live births:**	**Method of birth control:**	
Men Only			
Last prostate exam:		**Method of birth control:**	