Deborah Pyne, D.O.

Patient Information

Adult Intake Forms (18+ years)

2305 Coit Road, Suite C
Plano, Texas 75075

(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 to be answered.
- ☐ Bring all 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.
- ☐ 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.

Medicare Policy

To be completed by patients over 65 or those who qualify for Medicare.

Deborah Pyne, D.O. does not work for or participate with any private insurance or managed care companies. We, however, have chosen not to opt-out of government-provided Medicare insurance. This is for our existing patients as they age into Medicare coverage.

Existing Patients If you are over the age of 65 and have been treated by Dr. Pyne in the last 3 years, you may be eligible for a Medicare discount in our office.

New Patients Due to the nature of our practice, Dr. Pyne does not have the staff to maintain a large number of Medicare patients. We, therefore, do not accept new Medicare part B or Medicare Advantage patients unless on a special assignment. **Please do not complete this intake packet until you have verified your Medicare status with our office.**

Medicare Status

Please check all that apply:

- ☐ I have been treated by Dr. Pyne in the last 3 years
- ☐ I am over the age of 65
- ☐ I am an American citizen
- ☐ I am currently working full time
- ☐ I am currently unemployed or retired
- ☐ I currently get Medicare insurance directly through Medicare (Medicare Part B)
- ☐ I currently get Medicare insurance through a private insurance company (Medicare Advantage)
- ☐ I currently get additional coverage from a secondary private insurance company (Medigap)
- ☐ I currently get non-Medicare insurance through my/a family member's place of work
- ☐ I am currently un-insured

Medicare appointments are for **Osteopathic Treatment (OMT) only**. By signing below, you understand that you will need to retain your Primary Care Physician for all other services.

Name Date of Birth

Signature Date

Authorization to Release Health Information

please send anything over 10 pages by mail

Patient Name: _____ Date of Birth:_____

I authorize Name/Title: _____

Address: _____

_____

Telephone: _____ Fax: _____

To release my health information to:

Deborah Pyne, D.O.
2305 Coit Road, Suite C
Plano, Texas 75075
T: 972-733-1955 F: 972-733-1990

Type of Information:

- ☐ 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 any time. The revocation must be in writing and 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 you sign the form.

_____

Signature Name Date

General Information

Last Name: **First:** **Middle:** **Preferred Name:**			
Birth Date: **Age:**	**Sex:** ☐ M ☐ F ☐ _____	**Title:** **Pronouns:** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ _____	**Marital Status:** ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐ Divorced
Address:			
City: **Zip Code:**		**Mobile/Main Phone:** ✓ if we may leave messages on this line ☐	
Occupation: **Employer:**		**Home Phone:** ✓ if we may leave messages on this line ☐	
How did you hear about our office?		**Work Phone:** ✓ if we may leave messages on this line ☐	
Pharmacy: **Phone:**		**Email Address:** ✓ if you send messages to this email ☐	
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 ☐			

Signature Name Date

Health History

Name:	**Birth Date:**

List your desired goals by priority:	**List current and ongoing conditions or problems:**

Weight:	**Height:**	**Date & location of last physical:**

Immunizations and most recent date:

- ☐ COVID-19:_____
- ☐ Hepatitis A:_____
- ☐ Hepatitis B:_____
- ☐ Influenza (Flu):_____
- ☐ Zoster (Shingles):_____
- ☐ Meningococcal:_____
- ☐ Pneumococcal:_____
- ☐ HPV:_____
- ☐ Tdap (Tetanus, Diphtheria, Pertussis):_____
- ☐ Varicella (Chickenpox):_____
- ☐ MMR (Measles, Mumps,Rubella):_____
- ☐ Other:_____

Medical History:

- ☐ Allergies/Hayfever
- ☐ Arthritis/Rheumatism
- ☐ Asthma/Wheezing
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Seizures
- ☐ COVID-19
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy
- ☐ GERD
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Measles
- ☐ Mumps
- ☐ Osteoporosis/Osteopenia
- ☐ Peptic Ulcers
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Sexually Transmitted Infection
- ☐ Shingles
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Allergies (Medications, Food, Environment):

✓ if no known drug allergies ☐

Medication List (include prescribed drugs, over-the-counter medications, vitamins and supplements): ✓ if no medications ☐

medication:	strength:	dosing:	medication:	strength:	dosing:

List all significant family history. Include age the problem first occured:

	Father	Mother	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	NOTES
Alcoholism	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Asthma	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Bleeding Disorder	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Cancer	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Diabetes	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Epilepsy/Convulsions	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Glaucoma	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Heart Disease	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
High Blood Pressure	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Kidney Disease	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Mental Illness	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Migraine	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Osteoporosis	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Stroke	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
Thyroid Disease	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
_____	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____
_____	☐___	☐___	☐___	☐___	☐___	☐___	☐___	☐___	_____

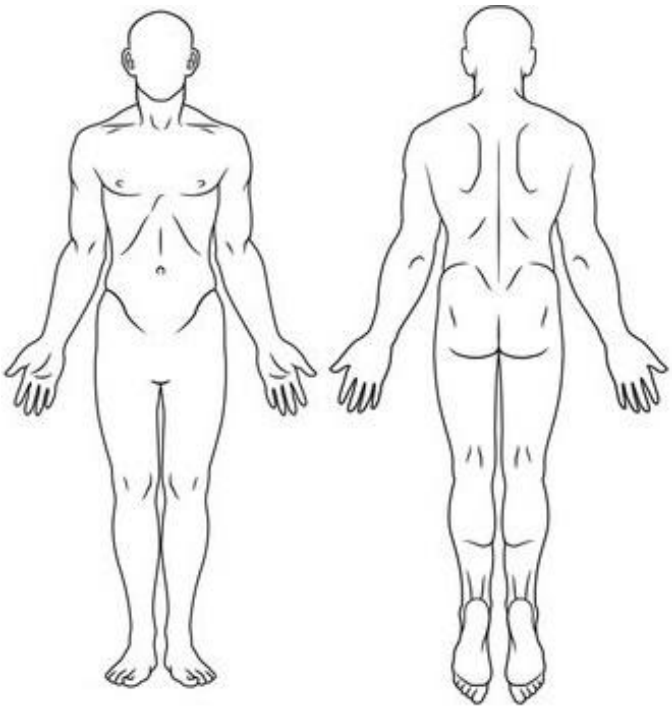
List past surgeries and hospitalizations:

Incident:	Date:	Reason:	Comments:

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

Injury/Trauma:	Date:	Comments:

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?

Significant Other:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
Family:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
Diet:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
Self:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
Sex:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
School:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
Work:	☐ Great	☐Good	☐Fair	☐Poor	☐Bad	Comments:_____
Exercise:	☐ 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?

Do you exercise regularly?
☐Yes ☐No

How many times a week?
☐1 ☐2 ☐3 ☐4+

What kind of exercises do you do?
☐Aerobics ☐Cardio Machines ☐Golf
☐Jogging/Walking ☐Pilates ☐Tennis
☐Weight Training ☐Yoga ☐Swim
☐Other: _____

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

Have you ever been exposed to toxic chemicals or metals?

☐Yes ☐No to what:

Do/did you smoke? ☐Yes ☐No

#of years #packs/day year quit

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

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/ well-formed ☐Brown ☐Greasy or shiny
☐ Thin, long, and narrow ☐Dark/black ☐Diarrhea
☐ Loose but not watery ☐Greenish ☐Often floats
☐ Small and hard ☐Yellow/light brown ☐Difficult to pass
☐ Alternating loose/hard ☐Color Varies

Do you ever experience gas?

☐Often ☐Occasionally ☐Rarely

Rate your intake:

Fruit	☐Low	☐Medium	☐High	servings/day:____
Vegetables	☐Low	☐Medium	☐High	servings/day:____
Protein	☐Low	☐Medium	☐High	servings/day:____
Fiber	☐Low	☐Medium	☐High	servings/day:____
Salt	☐Low	☐Medium	☐High	servings/day:____
Fat	☐Low	☐Medium	☐High	servings/day:____
Sugar	☐Low	☐Medium	☐High	servings/day:____
Processed Food	☐Low	☐Medium	☐High	servings/day:____
Water	☐Low	☐Medium	☐High	servings/day:____
Caffeine	☐Low	☐Medium	☐High	servings/day:____
Alcohol	☐Low	☐Medium	☐High	servings/day:____

How often have you taken antibiotics?

Childhood: ☐less than 5 times ☐more than 5 times **Adulthood:** ☐less than 5 times ☐ more than 5 times

How often have you taken steroids?

Childhood: ☐less than 5 times ☐more than 5 times **Adulthood:** ☐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_____

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

Colonoscopy:_____ Endoscopy:_____ Stress Test:_____

EKG:_____ Chest X-Ray:_____ Nerve Conduction Test:_____

Mammogram:_____ Bone Density:_____ Calcium Score:_____

CT Scans:_____ Part of Body: _____ X-Rays:_____ Part of Body: _____

_____ Part of Body: _____ _____ Part of Body: _____

Ultrasound:_____ Part of Body: _____ MRIs:_____ Part of Body: _____

_____ Part of Body: _____ _____ Part of Body: _____

Last pelvic exam/pap smear: _____

☐Normal ☐Abnormal

Last prostate exam: _____

☐Normal ☐Abnormal

Method of birth control:

Pregnancy: ☐ Currently Pregnant ☐ Trying/Planning

number of live births:____ abortions:____ miscarriages:____

Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain/Cramps

# of days:_____ last period:_____