Jennifer Lakis, D.O. *(formerly Jennifer Barrett)*

(p) 207-798-9677 158 Danforth Street, Suite 1, Portland ME 04102 (f) 207-569-6730

All Bolded fields on this page are MANDATORY, thanks.

Date: _____
Patient's Legal Name: _____ Name you go by**: _____**
Date of Birth: ____/____/_____Current Age: _____
Gender: M F Other Pronouns:_____
Relationship: Single Partnered Married Divorced Widowed Other
Street Address: _____
City: _____ State:_____ Zip code: _____

Primary Phone: _____ type: cell/home/work
Alternate Phone: _____ type: cell/home/work
Email address: _____

Emergency Contact: _____ Phone:_____
Spouse or Parents Name: _____

Primary Care Physician: _____ Phone: _____
Address: _____
Referring Physician: (if different from PCP) _____

Occupation: _____Employer: _____

Person responsible for payment (if not above)_____
Name and date of birth of Primary cardholder: _____
Phone: _____ Address: _____
City, State, Zip: _____
Primary Insurance: _____ ID# _____
Secondary Insurance: _____ ID# _____

Is this a work-related Injury? Y N Has your employer been notified? Y N
Date of Injury: _____ Claim # _____ Adjuster: _____
Adjuster's Phone: _____ Adjuster's Fax: _____

Is this injury a result of an accident? Y N Date of Accident: _____
Claim # _____ Attorney: _____

Please contact your primary care physician to make sure a referral has been sent to us if your insurance carrier requires one. You are fully responsible for payment in the event we do not receive the appropriate insurance referral authorization prior to your date of service. If you have an HMO plan, you most probably do need a referral from your PCP, which would include an insurance provider recognized referral authorization number, number of visits and expiration.

MEDICATIONS: (Include over the counter drugs, supplements and vitamins please.):

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

MEDICAL PROBLEMS:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

SURGICAL HISTORY:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

IMAGING STUDIES: (X-Rays, CT scans, MRI's etc.)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

DENTAL HISTORY:

1._____ 4._____

2._____ 5._____

3._____ 6._____

TRAUMA/INJURIES/ACCIDENTS:

1._____ 4._____

2._____ 5._____

3._____ 6._____

PREGNANCY HISTORY: Please include: *date, # of weeks of pregnancy, any prenatal problems, the type of delivery: Vaginal/C-Section and any complications during delivery.*

HEALTH MAINTENANCE/SOCIAL HISTORY

	Type	Frequency	#Years	Year quit	Never
Smoking					☐
Alcohol					☐
Drugs					☐
Caffeine					☐

Physical activity (type/frequency): _____

Hobbies (type/frequency): _____

Nutrition (tell us about your diet) _____

Spiritual practice? _____

Education, last grade completed: _____

Children? If yes, how many and ages:_____

HOME ENVIRONMENT

Who do you live with?: _____

Environmental exposure (Wood smoke, pets, mold, etc.…) _____

How is the quality of your home life? _____

EMPLOYMENT

Occupation: _____ Ergonomics: _____

How is the quality of your job? _____

If retired, what did you do prior to retirement?_____

FAMILY HISTORY

Ethnicity: Hispanic □ Non-Hispanic □ Race: _____

	Age	Health Problems	Age at death/cause
Mother:			
Father:			
Sisters:			
Brothers:			

CIRCLE IF PRESENT IN ANY BLOOD RELATIVES: (Include parents, grandparents, brothers, sisters children, cousins, aunts and uncles)

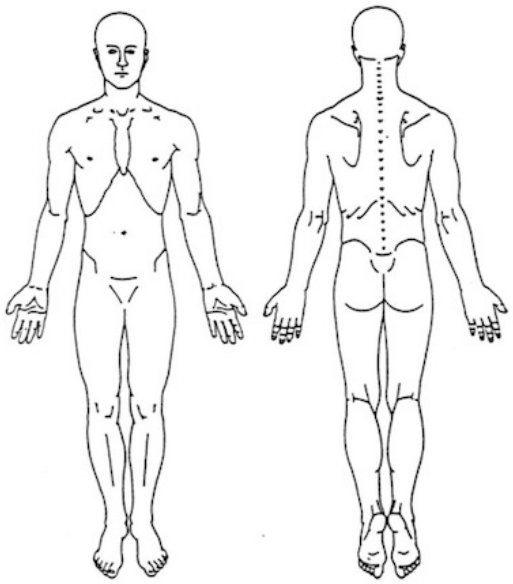
Diabetes	Heart Disease	High Blood Pressure	Lung Disease	Tuberculosis	Epilepsy
Migraines	Arthritis	Depression	Glaucoma	Suicide	Kidney Disease
Blood Disease	Obesity	Chronic Muscle Pain	Thyroid Disease	Ruptured Disc	
Alcoholism	Cancer (type)	Other: _____			

REASON FOR VISIT TODAY:

LOCATION OF PAIN:

Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

"N"=Numbness
"S"=Stabbing
"B"=Burning
"P"=Pins and needles
"A"=Aching Pain



How did your current episode begin? Suddenly □ Gradually □

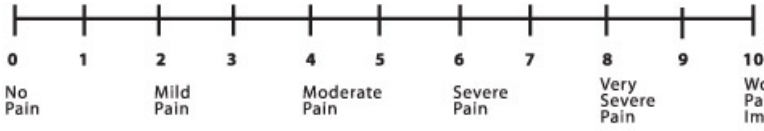
Describe the onset of the pain:

How long ago did the current episode begin? _____

Has the pain lessened, stayed the same, or worsened? _____

What does the pain feel like? (circle all that apply):

Throbbing
Tiring/Exhausting
Tender
Hot/Burning
Heavy
_____



How bad is your pain **TODAY**, on a scale of 0-10 with 0 being no pain, and 10 being the worst pain imaginable.

Which number (0-10) describes your pain at its WORST? _____

Which number (0-10) describes your pain at its LEAST? _____

Have you consulted any other healthcare practitioner for pain relief of your current problem? If so, please list:

Please mark all the following treatments that you have used for pain relief:

	Helped Pain	worsened pain	no change
massage therapy	☐	☐	☐
hot packs	☐	☐	☐
ice	☐	☐	☐
traction	☐	☐	☐
brace support	☐	☐	☐
tens	☐	☐	☐
injection therapy	☐	☐	☐
oral medications	☐	☐	☐

Mark the effect of each of the following on your pain:

	Increases	Decreases	No change
sitting	☐	☐	☐
standing	☐	☐	☐
rising from sitting	☐	☐	☐
bending forward	☐	☐	☐
bending backward	☐	☐	☐
walking	☐	☐	☐
climbing stairs	☐	☐	☐
lying on your back	☐	☐	☐
lying on your stomach	☐	☐	☐
driving	☐	☐	☐
coughing/sneezing	☐	☐	☐
lifting objects	☐	☐	☐

PLEASE MARK ALL THAT APPLY:

GENERAL

- Weight Gain or Loss
- Change in Appetite/Thirst
- Fatigue
- Weakness
- Change in Sleep Patterns
- Fever
- Chills
- Night Sweats
- Cold Intolerance
- Change in Hair/Skin
- Easy Bruising
- Irritability/Indifference
- Tick bites

HEAD/ EYES/ EARS/ NOSE/ THROAT

- Eye Pain/Disease
- Visual Problems/ Wears Glasses
- Ear Pain/ Frequent Ear Infections
- Ringing in Ears
- Hearing Problems
- Chronic Sinusitis
- Nasal Discharge
- Lost sense of taste/smell
- Difficulty Swallowing
- Sore Throat
- Swollen Glands
- Hoarseness

SKIN

- Itching
- Psoriasis/Eczema
- Lumps
- Change in Moles/ Warts/ Lesions
- History of Cancer
- Other Rash

MUSCULOSKELETAL DISEASE

- Joint Pain
- Redness/Swelling
- Joint Stiffness
- Frequent/Severe Muscle Pain
- Muscle weakness
- Osteoarthritis
- Autoimmune condition
- Disc Degeneration/Herniation
- Abnormal Spinal Curve

CARDIOVASCULAR

- Angina
- Palpitations
- Arrhythmia
- Heart Murmurs
- Blood Vessel Disease
- Clots
- Foot/Ankle Swelling
- Heart Attack
- Heart Failure
- Chest Pain
- Hypertension

RESPIRATORY

- Wheeze
- Asthma
- Use of Inhalers
- Shortness of Breath
- Frequent Cough
- Bronchitis
- COPD
- Pneumonia
- Flu
- H/O Covid

GASTROINTESTINAL

- Nausea/Vomiting
- Abdominal Pain
- Ulcer
- Change in Bowel Habits
- Constipation
- Irritable Bowel Syndrome
- Excessive Gas
- Food Intolerance
- Crohn's disease/Ulcerative Colitis
- Liver/Gall Bladder problems
- Acid Reflux
- Hiatal Hernia

NERVOUS SYSTEM

- Numbness/Tingling
- Loss of Coordination
- Seizures
- Tremors
- Headaches Dizziness/Vertigo
- Poor Memory
- Stroke/TIA
- Fainting
- Neurological Disease

BLOOD/LYMPH

- Anemia
- Bleeding
- Jaundice

PSYCHOLOGICAL/ENDOCRINE

- Often Nervous/Worries
- Constant Feelings of Sadness/Hopelessness
- Decreased Sense of Well-Being/Energy
- Decreased Mental Sharpness/Forgetful
- Hospitalized for Mental Illness
- Psychological Diagnosis
- Complex Childhood Trauma
- PTSD
- ADHD
- Autism Spectrum
- History of Thyroid Disease

URINARY

- STD'S
- Frequent UTI
- Pain with Urinating
- Incontinence
- Kidney Stones

FEMALE ENDOCRINE/REPRODUCTIVE

- Sexual Dysfunction
- Decreased Desire
- Pain with Intercourse
- Menstrual Irregularity/Flow
- Bloating
- PMS
- Endometriosis
- Fibroids
- Infertility
- Miscarriages
- Menopausal
- Perimenopausal
- Breast Lumps/pain

MALE ENDOCRINE/REPRODUCTIVE

- Erectile Dysfunction
- Sexual Dysfunction
- Decreased Desire
- Prostate Disease
- Infertility

ALLERGIES

MARK ALL THAT APPLY:

□ No known FOOD allergies
□ No known DRUG allergies
□ No known ENVIRONMENTAL allergies

IF YOU HAVE AN ALLERGY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

1. Medication/Food/Other: _____ Start Date: _____
Reaction: □ Mild □ Moderate □ Severe □ Very Severe

Abdominal:
□ Pain/Cramping
□ Bloating/Gas
□ Vomiting
□ Diarrhea
□ Nausea

Skin:
□ Rash (localized)
□ Rash (general)
□ Itchiness
□ Patchy/Swelling
□ Facial Swelling
□ Hives

Local:
□ Conjunctivitis
□ Runny Nose
□ Cough

Systemic:
□ Shortness of Breath
□ Wheezing
□ Dizziness
□ Swelling Tongue
□ Difficulty Speaking/Swallowing
□ Loss of Consciousness
□ Fast/Slow/Irregular Heartbeat
□ Chest Pain

2. Medication/Food/Other: _____ Start Date: _____
Reaction: □ Mild □ Moderate □ Severe □ Very Severe

Abdominal:
□ Pain/Cramping
□ Bloating/Gas
□ Vomiting
□ Diarrhea
□ Nausea

Skin:
□ Rash (localized)
□ Rash (general)
□ Itchiness
□ Patchy/Swelling
□ Facial Swelling
□ Hives

Local:
□ Conjunctivitis
□ Runny Nose
□ Cough

Systemic:
□ Shortness of Breath
□ Wheezing
□ Dizziness
□ Swelling Tongue
□ Difficulty Speaking/Swallowing
□ Loss of Consciousness
□ Fast/Slow/Irregular Heartbeat
□ Chest Pain

3. Medication/Food/Other: _____ Start Date: _____
Reaction: □ Mild □ Moderate □ Severe □ Very Severe

Abdominal:
□ Pain/Cramping
□ Bloating/Gas
□ Vomiting
□ Diarrhea
□ Nausea

Skin:
□ Rash (localized)
□ Rash (general)
□ Itchiness
□ Patchy/Swelling
□ Facial Swelling
□ Hives

Local:
□ Conjunctivitis
□ Runny Nose
□ Cough

Systemic:
□ Shortness of Breath
□ Wheezing
□ Dizziness
□ Swelling Tongue
□ Difficult Speech/Swallowing
□ Loss of Consciousness
□ Irregular Heartbeat
□ Chest Pain

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- **NOTICE OF ACKNOWLEDGEMENT:** I acknowledge that I have received the notice of privacy practices posted in the office. I understand that a copy of our privacy practices is available to me upon request.
- Signature: _____ Date: _____
- Print Name: _____ DOB: _____

- **AUTHORIZATION OF PAYMENT:** I authorize payment of my medical benefits to Jennifer Lakis, D.O. for services rendered. I understand that I am financially responsible in the event that payment is denied or rejected by the insurance company and for those charges not covered by policy benefits, as well as deductibles and co-insurance that are not covered by this assignment.
- Signature: _____ Date: _____

- **RELEASE OF NECESSARY MEDICAL INFORMATION:** During the course of my treatment I understand that certain tests, such as an MRI, CT Scan, or consultations with other physicians may be necessary. I authorize the release of any medical information for these purposes. I authorize the release of any medical information for these purposes. I authorize the release of any medical information necessary to process my disability and/or medical claim.
- Signature: _____ Date: _____

- **LATE CANCEL AND NO-SHOW POLICY:** All patients are granted one late cancel without additional charge per calendar year. There is a $25 charge for any appointment cancelled less than 24 hours of the scheduled time. There is a $100 charge for any no-show to an appointment. I understand that arriving more than fifteen minutes late for any scheduled appointment will be considered a no-show and treatment is not guaranteed.
- Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

- **MEDICARE RELEASE OF NECESSARY MEDICAL INFORMATION**: I authorize any holder of medical or other information about me to be released to the social security administration, health care financial administration or it's intermediaries/carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments, I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatments of any changes. (Section 1128(B) of the social security act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.
- Signature: _____ Date: _____

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- **CONSENT TO TREAT**

  I, _____, do hereby consent to evaluation, medical care, and the administration of Osteopathic manipulative treatment and/or medical acupuncture by Dr. Jennifer Lakis.
- Signature of Patient: _____ _____

FOR OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORTS: *the patient presented for treatment on this date and was provided with a copy of the notice of privacy practices. A good faith effort was made to obtain a written acknowledgement or receipt of the notice. However, an acknowledgement was not obtained for the following reason: _____. Patient name: _____*
Signature of physician or employee: _____ Date: _____