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.

Date: _____
Patient's Legal Name: _____ Name you go by:_____
Patient's Legal Guardian Names:_____
Date of Birth: ____/____/_____Current Age: _____
Gender: M F Other_____ Pronouns:_____
Street Address: _____
City: _____ State:_____ Zip code: _____

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

Emergency Contact: _____ Phone:_____

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

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

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.

Parent 1/title: _____ Parent 2/title: _____

MEDICATIONS: (Please include over the counter drugs, supplements, and vitamins):

1._____ 3._____

2._____ 4._____

MEDICAL PROBLEMS:

1._____ 3._____

2._____ 4._____

SURGICAL HISTORY:

1._____ 3._____

2._____ 4._____

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

1._____ 3._____

2._____ 4._____

IMMUNIZATION INFO:(Up to Date/Delayed/specify other)_____

BIRTH HISTORY:

Number of weeks: _____ Prenatal Problems: _____

Duration of labor/Pushing: _____/_____ Delivery Type (vaginal or C-section): _____

Procedures/Complications: _____

Condition at Birth: _____

TRAUMA HISTORY: (please give details and approximate dates)

Head trauma: _____

Motor Vehicle Accidents: _____

Injuries: _____

Dental Work: _____

Emotional traumas: _____

Other: _____

HOME ENVIRONMENT:

Who does your child live with? _____

Environmental exposures (wood smoke, pets, mold, etc.): _____

Quality of home life? _____

DEVELOPMENTAL HISTORY:

Age appropriate milestones (motor skills, language, etc.)? If not, please explain: _____

Academic/Athletic Performance: _____

Social Skills (with peers, adults, friends): _____

Grade in school? _____

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HEALTH MAINTENANCE:

Physical Activity (type/frequency): _____

Hobbies (type/frequency): _____

Nutrition (tell us about your child's dietary intake): _____

Fluid Intake: _____

Sleep/Rest (hours per day/quality): _____

Tobacco/alcohol/drug use? _____

Familial spirituality/beliefs? _____

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 Kidney Disease Depression Glaucoma Suicide
Obesity Blood DiseaseChronic Muscle Pain Thyroid Disease Degenerative Discs
Cancer (type) _____
Other _____

WHAT IS THE REASON FOR TODAY'S VISIT?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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LOCATION OF PAIN/COMPLAINT:

Use this diagram to indicate the location and type of pain, discomfort, or concern. Mark the drawing with the following letters that best indicate your child's symptom

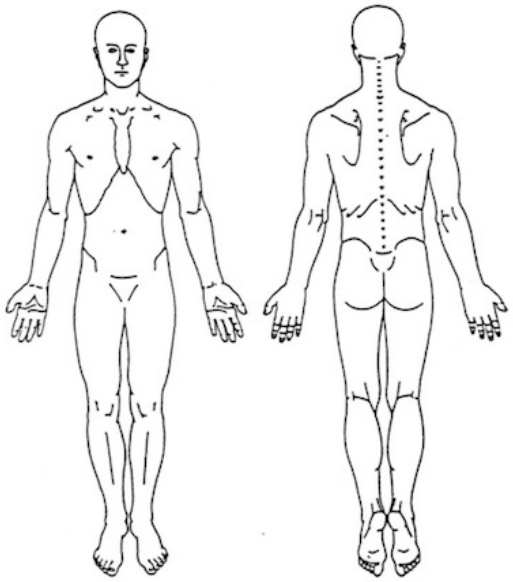
"N"=Numbness

"S"=Stabbing

"B"=Burning

"P"=Pins and needles

"A"=Aching Pain



How did your child's current episode begin? Suddenly □ Gradually □

Describe the onset of the pain:

_____

_____

_____

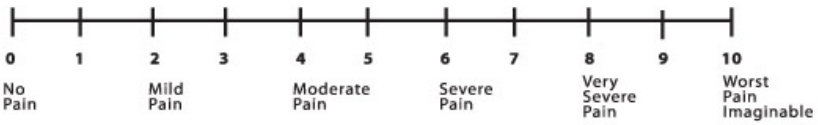
How long ago did the current episode begin? _____

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

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

Throbbing	Splitting	Shooting	Stabbing	Hot/Burning
Tiring/Exhausting	Aching	Sickening	Sharp	Heavy
Tender	Gnawing	Cramping	Other: _____	

How bad is the 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 the pain at its worst? _____

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

_____

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Please mark all the following treatments that has been 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 child's 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	☐	☐	☐

Any other medicines/treatments/activities/factors that make condition better or worse?

_____

_____

_____

_____

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
- Anemia
- Bleeding problems
- 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
- Lost sense of smell/taste
- Nasal Discharge
- Difficulty Swallowing
- Sore Throat
- Swollen Glands

SKIN

- Itching
- Rash
- Psoriasis/Eczema
- Lumps
- Change in Moles/ Warts/ Lesions

MUSCULOSKELETAL

- Joint pain
- Red/hot/swollen joints
- Family history of autoimmune disease/arthritis
- Decreased range of motion
- Muscle spasms
- Congenital deformity
- Muscle/connective tissue disease
- Spinal curvature
- Torticollis/plagiocephaly as an infant

CARDIOVASCULAR

- Chest pain
- Palpitations
- Arrhythmia
- Heart Murmurs
- Congenital heart defects
- Blood Vessel Disease
- Clots
- Foot/Ankle Swelling
- Heart Failure

RESPIRATORY

- Wheeze
- Asthma
- Use of Inhalers
- Shortness of Breath
- Frequent Cough
- Bronchitis
- Pneumonia
- History of Covid
- Lung problems from prematurity

GASTROINTESTINAL

- Nausea/Vomiting
- Abdominal Pain
- Food allergy/intolerance
- Acid reflux
- Hiatal Hernia
- Change in Bowel Habits
- Irritable Bowel Syndrome
- Excessive Gas
- Bloating
- Constipation
- Crohn's/ulcerative colitis
- Jaundice

EDOCRINE/REPRODUCTIVE

- Menarche:_____
- Regular menstrual cycle?____
- Menstrual pain/cramping
- Bloating
- PMS
- Breast Lumps
- Testicular pain/lumps/problems
- Sexually active
- History of Thyroid Disease

URINARY

- Pain with Urinating
- Frequent UTI's
- Incontinence
- Kidney problems

NERVOUS SYSTEM

- Seizures
- Tremors
- Headaches
- Head Injury
- Numbness/Tingling
- Loss of Coordination
- Dizziness/Vertigo
- Poor Memory
- Fainting
- Change in Taste or Smell
- Neurological Disease

PSYCHOLOGICAL/ENDOCRINE

- Often Nervous/Worries
- Decreased Sense of Well-Being/Energy
- Constant Feelings of Sadness/Hopelessness
- Psychological Diagnosis
- Hospitalized for Mental Illness
- Decreased Mental Sharpness/Forgetful
- ADHD
- PTSD
- Autism spectrum

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:	Skin:	Local:	Systemic:
□ Pain/Cramping	□ Rash (localized)	□ Conjunctivitis	□ Shortness of Breath
□ Bloating/Gas	□ Rash (general)	□ Runny Nose	□ Wheezing
□ Vomiting	□ Itchiness	□ Cough	□ Dizziness
□ Diarrhea	□ Patchy/Swelling		□ Swelling Tongue
□ Nausea	□ Facial Swelling		□ Difficulty Speaking/Swallowing
	□ Hives		□ Loss of Consciousness
			□ Fast/Slow/Irregular Heartbeat
			□ Chest Pain

2. Medication/Food/Other: _____ Start Date: _____

Reaction: □ Mild □ Moderate □ Severe □ Very Severe

Abdominal:	Skin:	Local:	Systemic:
□ Pain/Cramping	□ Rash (localized)	□ Conjunctivitis	□ Shortness of Breath
□ Bloating/Gas	□ Rash (general)	□ Runny Nose	□ Wheezing
□ Vomiting	□ Itchiness	□ Cough	□ Dizziness
□ Diarrhea	□ Patchy/Swelling		□ Swelling Tongue
□ Nausea	□ Facial Swelling		□ Difficulty Speaking/Swallowing
	□ Hives		□ Loss of Consciousness
			□ Fast/Slow/Irregular Heartbeat
			□ Chest Pain

3. Medication/Food/Other: _____ Start Date: _____

Reaction: □ Mild □ Moderate □ Severe □ Very Severe

Abdominal:	Skin:	Local:	Systemic:
□ Pain/Cramping	□ Rash (localized)	□ Conjunctivitis	□ Shortness of Breath
□ Bloating/Gas	□ Rash (general)	□ Runny Nose	□ Wheezing
□ Vomiting	□ Itchiness	□ Cough	□ Dizziness
□ Diarrhea	□ Patchy/Swelling		□ Swelling Tongue
□ Nausea	□ Facial Swelling		□ Difficult Speech/Swallowing
	□ Hives		□ Loss of Consciousness
			□ Irregular Heartbeat
			□ Chest Pain

- **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: _____

- **CONSENT TO TREAT MINOR CHILDREN**
  I, _____, parent or legal guardian of _____, born _____, do hereby consent to evaluation, medical care, and the administration of Osteopathic manipulative treatment by Dr. Jennifer Lakis to be necessary for the welfare of my child.
- Signature of Parent or Legal Guardian _____ _____

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: _____