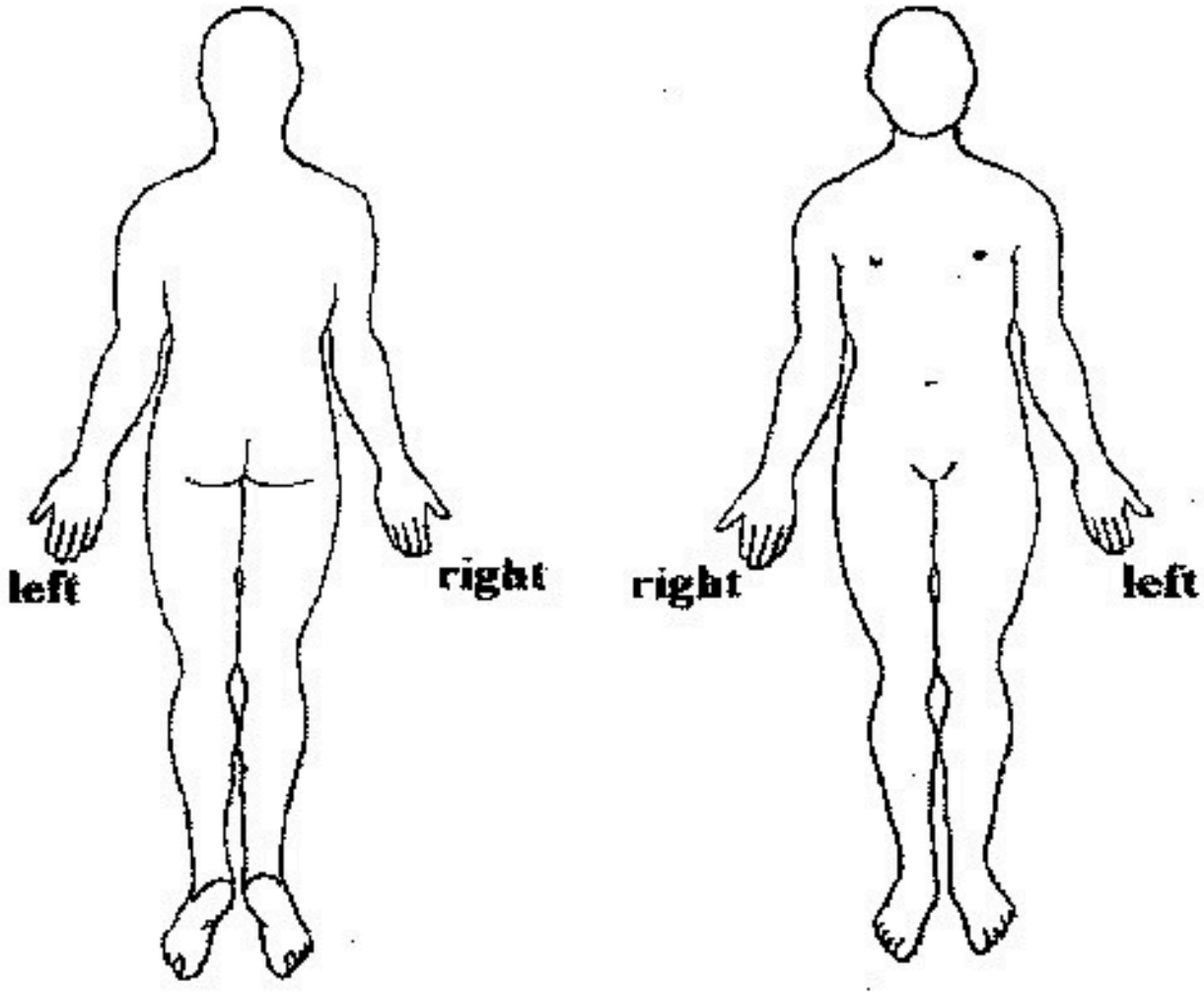
Missoula Osteopathic Clinic, PLLC
341 W Pine St. Missoula, Montana. 59802
(406) 327-0269, (406) 327-0264 Fax

# Pain Diagram

Name _____ Date _____

Draw the location of your pain on the body outlines below. Use the appropriate colored pencil (or letter code) to denote the kind of pain you are having now. Using a pen, draw all scars that are on your body.

| ACHE | BURNING | NUMBNESS | PINS & NEEDLES | STABBING | OTHER | SCARS |
|---|---|---|---|---|---|---|
| Brown or "A" | Red or "B" | Blue or "N" | Orange or "P" | Green or "S" | Yellow or "O" | Black "++" |




No pain (----------) Worse possible pain

Please mark on the pain line what you feel your average pain is.

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# Intake Information

Date_____

Name_____ Date of Birth_____
Last First Middle

Age_____Occupation_____

Address _____

_____

Preferred Phone_____ E-Mail_____

Social Security #_____

Health Insurance Company_____

Secondary Health Insurance_____

Primary Policy Holder_____
Last First

Policy Number_____

Primary Policy Holder Date of Birth_____

Emergency Contact_____ Relationship_____

Phone_____

Are you being seen for work related complaint? Y / N (circle one)

If yes, Date of Injury/Accident_____

**Insured Patients Please read and sign.**

I hereby assign my right and authorize and direct my insurance company, or any other liable insurance company, or any other concerned party, including but not limited to Medicare, to make payment directly to Missoula Osteopathic Clinic, PLLC and/or Sam Wallace D.O. This assignment and direct payment authorization shall include any payments for the doctors services rendered at Missoula Osteopathic Clinic, PLLC.
*I understand that I am responsible for any amount billed that my insurance company does not cover.*

Authorization Signature:_____

With the rise of high-deductible insurance plans and varying coverage limitations, it is possible to receive a bill you weren't expecting. We encourage you to verify your benefits with your insurance provider before your visit. If you are uninsured, have Medicaid, VA coverage, or don't anticipate meeting your deductible, please ask us about our prompt-pay pricing options. If you ever receive a surprising bill, don't panic—reach out. We're here to help. Contact our office manager by calling the clinic or emailing missoulaosteopathic@gmail.com. We offer budget-friendly payment plans and are happy to work with you.

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# Patient History - 1

**Problem List (symptoms or complaints)** Date Began

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Medical Tests For Primary Concern (XRays, MRIs, CAT scans, Blood Test or other)**

| Date | Facility | Result |
|---|---|---|
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |

**Past Medical Problems, Diagnoses, and Hospitalizations**

| Date | Reason |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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# Patient History - 2

## Medications and Supplement Currently Used

| Name | Date Began | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Past Surgeries

| Date | Reason | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Medication Allergies

| Name | Reaction |
|---|---|
| | |
| | |
| | |

Birthplace_____ Residence past 5 years_____

List all states lived in_____

Occupation_____ For how long_____

( )Married ( )Single ( )Divorced ( )Separated ( )Widowed

Highest Level of Education Completed? (circle one)

Grade School / High School / College / Masters / Doctorate

Alcohol Use (Drinks per day)_____ Type of Alcohol_____

Size of typical drink in ounces_____ Problems with Alcohol NO / YES / UNSURE (circle one)

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# Patient History - 3

Tobacco/Nicotine/Cannabis Use: YES / NO

Type Used_____ Amount per day _____ Years_____

Caffeinated Beverages: YES / NO

Type Used_____ Amount per day_____ Years_____

Water Intake per day:_____

Pain Reliever Use: YES / NO

Type Used_____ Amount per day_____ Years_____

Illicit Drug Use: YES / NO

Type Used_____ Amount per day_____ Years_____

Activity Level: Very Active Moderately Active Lightly Active Sedentary

Family History

Father Living Deceased Age _____Illnesses: _____

Grandfather Living Deceased Age_____ Illnesses: _____

Grandmother Living Deceased Age_____ Illnesses:_____

Mother Living Deceased Age_____ Illnesses:_____

Grandfather Living Deceased Age_____ Illnesses:_____

Grandmother Living Deceased Age_____ Illnesses: _____

Date of Last Full Physical Exam:_____ Blood Test:_____

***Circle applicable medical concerns:***

General: Fever Chills Sweats Weight Loss Weight Gain Night Sweats Fatigue

Skin: Dryness Itching Rashes Acne Growths Bruising

Nails: Ridging Brittle Discolored

Lymph Nodes: Swollen glands Painful

Endocrine: Changes in appetite Sensitive to heat or cold Extreme thrist Increased urination

Head: Headaches Migraine Trauma Dizziness Fainting Seizures

Eyes: Blurring Glasses Contacts Surgery Cataracts Pain

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# Patient History - 4

***Circle applicable medical concerns:***

Ears: Deafness Tinnitus Spinning sensations Drainage Pain

Nose: Sinus Infection Congestion Bleeding Blockage Use of drugstore nasal sprays

Mouth: Canker sores Gum bleeding Toothaches Mercury fillings Pulled teeth Braces

Retainers Other dental procedures:_____

Throat: Soreness Loss of voice Change in voice

Neck: Swelling Swollen glands Stiffness

Breasts: Lumps Pain Nipple discharge

Date of last mammogram:_____ Result:_____

Respiratory: Difficulty breathing: With exercise At night When lying down

Wheezing Cough Mucus Painful breathing Tuberculosis exposure Pneumonia

Asthma Emphysema

Cardiovascular: Chest pain or tightness Skipped heartbeats Swelling in feet or belly

Pain in legs when walking (helped by resting) Blue toes or fingers Cold feet

History of rheumatic fever Heart murmurs High blood pressure

Gastrointestinal: Painful swallowing Difficulty swallowing Nausea Pain in abdomen

Jaundice Diarrhea Constipation Vomiting Blood or coffee grounds appearing in vomit

Bloody stools Tarry stools Hemorrhoids Rectal pain Hernia

Genitourinary: Frequent urination Absent urination Painful urination Blood in urine

Pain in sides Incontinence of urine Frequent urination at night Kidney stones

History of bladder or kidney infection

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# Patient History - 5

***Circle applicable medical concerns:***

Musculoskeletal: Neck pain Back pain Muscle pain Muscle weakness Carpal tunnel

Joint pain (specify): _____

Joint instability (specify): _____

Neurological: Weakness Paralysis Numbness Shakes Seizures Tingling

Mental Health: Anxiety Depression Mood swings Difficulty sleeping

Sleeping too much Delusions Hallucinations

Female Only: Bladder prolapse Difficulty climaxing Vaginal dryness or discomfort

Age of first period Age of end of periods

If still having periods, are they regular? _____ How long are your cycles _____

Date of last Pap Smear _____ Results _____

Number of pregnancies _____ Dates _____

Births _____ Episiotomies _____

**Additional information you would like to be disclosed with your medical provider:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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**Acknowledgement of Receipt of**
**Notice of Privacy Practices**

## HIPAA Acknowledgment

I understand that Missoula Osteopathic Clinic follows HIPAA guidelines to protect my personal health information. I have been informed that my information will only be shared for treatment, billing, and healthcare operations, or as required by law.

## AI-Assisted Notes Acknowledgment

I understand that my provider may use HIPAA-compliant, AI-assisted tools to help with documentation. All notes are reviewed by my provider, and my information is kept secure and confidential.

I have received a copy of the Notice of Privacy Practices. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

_____

Patient's Signature or Guardian

_____

Date Signed

**Provider Use Only**

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _____Yes _____No

Reason signature was not obtained_____

_____

_____

_____

Staff Signature Date

_____

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# Clinic Courtesy and Care Guidelines

## Attire for Treatment

For your comfort and ease of movement during osteopathic care, we kindly ask that you wear loose-fitting, comfortable clothing to your appointments.

## Dental Appliances

If you wear a dental appliance (such as a night guard, retainer, or splint), please bring it with you to each appointment. Your provider may ask you to wear it during treatment, as it can help support and stabilize your osteopathic care.

## Waiting Room Courtesy

Our clinic is intentionally quiet and peaceful, and our walls are thin. To respect patients who may be receiving care nearby, we ask that you:

- Use low voices when speaking in the waiting area.
- Refrain from loud or disruptive noise.
- Avoid using your cellphone on speaker.
- Please use headphones if you are listening to audio or watching videos on your device.

## Preparing for Your Visit

Before entering your provider's treatment room, we ask that you please remove your shoes, belt, and any metal items (such as jewelry) from your body, as these can interfere with certain treatments.

## Room Turnover & Check-In

After each appointment, your provider takes a moment to clean and prepare the room for the next patient. Please remain in the waiting area until your provider or staff member invites you back.

## Phone Communication

We appreciate you calling our clinic with questions or to schedule appointments. If we are unable to answer your call, our voicemail message includes our office hours and an emergency contact number. If you would like to bypass the introductory message and leave a voicemail directly, please press # and we will return your call as soon as possible.

*Thank you for helping us maintain a calm, respectful, and healing environment for everyone who visits our clinic.*

I have read and understand the Clinic Courtesy and Care Guidelines.

_____

Patient's Signature or Guardian

_____

Date Signed

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# Cancellation Policy

## Please read carefully and sign

Due to an increase in patient demand we can no longer allow less than a 24-hour notice to cancel an appointment. We are trying to accommodate everyone and apologize for any inconvenience this may cause. If you do not give 24 hours notice you will be charged the **cost of a full appointment** for the missed appointment. You are responsible for this; your insurance company will not pay this fee.

If unforeseen circumstances arise and you are able to give notice that is less than 24 hours we will do our best to fill the vacancy. If we are able to do so, you will not be charged. The more notice you can give the better able we are to accommodate other patients who may be on a waiting list.
Thank You

**I agree to Missoula Osteopathic Clinic, PLCC Cancellation Policy**

_____
Please Print Name

_____
Signature

_____
Date

MISSOULA OSTEOPATHIC
CLINIC

# *Regenerative Medicine Offerings and Price*

**Laser therapy:** A powerful, non-invasive regenerative tool that stimulates cellular healing at the source. Over a series of sessions, laser therapy can significantly reduce pain, improve mobility, and accelerate recovery. Laser therapy pairs exceptionally well with injection-based and osteopathic treatments to enhance overall regenerative outcomes.

Laser therapy sessions are offered at the rate of $60 per session, making it an affordable addition to your healing and wellness plan. Many patients incorporate it into their osteopathic treatment schedule for enhanced results.

- 15 min Laser ONLY appointment**:** $60 out of pocket
- Osteopathic Treatment  with Laser Therapy add-on**:** $60 out of pocket. The osteopathy portion to be billed to insurance OR $120 out of pocket for the entire office visit

We offer full spine rejuvenation package of 40 sessions for $2000.

**Schedule a visit with Heather Kelly, PA-C or Jason Postlethwaite, D.O. for laser therapy.**

**Injection Therapy for Comprehensive Joint Regeneration:** Using the healing properties of platelets derived from your own blood, we employ *a specialized injection technique* unlike any other platelet-rich injection therapy you may see, designed to support tissue repair and joint restoration. Many patients experience significant improvement in joint function and comfort. Typically, two treatment sessions are recommended, though some cases may benefit from a third.

Cost: $1,200-$2,400 per session based on area of the body.

**$1200 Tier**

- Wrist
- Elbow
- Foot
- Jaw

**$1800 Tier**

- Shoulder
- Hip
- Knee
- Ankle

**$2400 Tier**

- Cervical spine
- Lumbar spine/SI joint

**Schedule an injection consultation with Jason Postlethwaite, D.O.**

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