Osteopathy Consent and Intake Form

Please fill out these forms completely and to the best of your knowledge.

Full Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ (Work): _____ (Cell): _____

E-Mail: _____

Date of Birth _____ Gender: _____

Occupation: _____

Primary Physician: _____ Phone: _____

Other Healthcare Practitioners that you are seeing:

1. _____ Reason: _____

2. _____ Reason: _____

3. _____ Reason: _____

How did you hear about us? ☐ Doctor ☐ Other Health Practitioner ☐ Website

☐ Signage ☐ Word of Mouth Other: _____

This is a confidential record of your medial history and will be kept in this office.

Information contained in it will not be released to any person unless you authorize to do so.

The health information requested on the following forms will assist us in treating you in the most efficient and safe way possible. If you have any questions about the requested information please feel free to ask. Your written permission is required to release any information, unless required by law.

Health and Lifestyle Information

What is your main health concern?

_____

_____

_____

_____

Please list any other health concerns in order of importance (Physical, Emotional, Mental):

1. _____
2. _____
3. _____
4. _____

Please list any dietary restrictions and/or allergies: _____

_____

How much water do you drink per day? _____

How many and what type of alcoholic beverages do you have per week?

_____

Do you smoke? Y / N How many cigarettes daily? _____

Have you ever smoked? Y / N When did you quit? _____

On average how many hours do you sleep a night? _____

Do you have trouble falling asleep? Y / N Possible reason: _____

Do you wake up during the night? Y / N Any specific time or reason? _____

Do you exercise regularly? Y / N

What type of exercises and how often? _____

_____

Have you <u>ever</u> experienced pain or injury to?

☐ Shoulders	☐ Hips	☐ Head	☐ Sacroiliac Joints
☐ Arms	☐ Legs	☐ Neck	☐ Pelvis
☐ Elbows	☐ Knees	☐ Mid back	
☐ Hands	☐ Feet	☐ Lower Back	

Briefly provide relevant details:

_____

_____

_____

Health History

Check off and explain (dates, procedures, etc.) in the space below:

☐ Yes ☐ No Have you ever been in a car accident?

☐ Yes ☐ No Have you ever experienced a hard fall onto your back or buttocks?

☐ Yes ☐ No Have you ever experienced a hard blow to your head or a concussion?

☐ Yes ☐ No Have you ever had any Surgical procedure?

☐ Yes ☐ No Do you have a pin, plate, screw or other implant in your body?_____

_____

Current Medications: Reason for Taking Medication:

_____ _____

_____ _____

_____ _____

Supplements / Herbal Medicine: Reason for Taking Supplements / Herbal Medicine:

_____ _____

_____ _____

Do you at the present time experience:

☐ Yes ☐ No Dizziness, weakness, fainting, vertigo, drop attack or disorientation?

☐ Yes ☐ No Disturbances of vision, speech, balance or difficulty swallowing?

☐ Yes ☐ No Numbness or pins and needles in any part of your body?

Where? _____

☐ Yes ☐ No Difficulty with bowel or bladder function?

☐ Yes ☐ No Cough, shortness of breath, chest pain, or palpitations?

☐ Yes ☐ No Poor appetite, nausea or vomiting?

☐ Yes ☐ No A significant weight change in the past year?

Have you ever experienced:

☐ Yes ☐ No Recurrent ear, throat or sinus infection?

☐ Yes ☐ No Respiratory disease or disorders? (i.e. asthma, pneumonia, bronchitis, etc.)

☐ Yes ☐ No Stomach, intestinal or any digestive problems?

☐ Yes ☐ No Bladder or kidney problems? (i.e. Infection, disease, etc.)

☐ Yes ☐ No Gynecological conditions? (i.e. Endometriosis, cysts, fibroids, polyps, etc.)

☐ Yes ☐ No Have you ever consulted a physician for any of the above?

If Yes, please explain: _____

_____

_____

Do you have any of the following conditions?

- ☐ Diabetes
- ☐ Cancer
- ☐ Tumor
- ☐ Allergies / In-tolerances

_____

_____

_____

_____

_____

_____

- ☐ Heart Disease / Problems
- ☐ High / Low Blood Pressure
- ☐ Stroke / CVA
- ☐ Epilepsy (Type)

_____

- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Anxiety
- ☐ Depression
- ☐ Headaches (Type)

_____

- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ STDs
- ☐ Tuberculosis
- ☐ Arthritis (Type)

_____

- ☐ Skin Conditions

_____

- ☐ Any Other Conditions?

_____

_____

_____

Women's Health

Are you currently pregnant? Y / N

Is your period regular? Y / N

Is your period painful? Y / N

Do you experience low back pain? Y / N

Any other symptoms? _____

Length of monthly cycle (Days): _____

Average length of period and flow (Days): _____

Do you get regular Pap smears? Y / N

Date of last Pap smear: _____

Are you menopausal? Y / N

If yes, date of last period: _____ Current forms of contraception: _____

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

No. of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____ C-Sections: _____

Men's Health

Do you have regular screening tests done (blood work, prostate examination)? Y / N

Date of last prostate examination? _____

What are the results of the prostate examination? _____

Do you have difficulty urinating completely? Y / N

Do you feel any burning or pain while urinating? Y / N

How many times do you get up from your sleep to go to the bathroom at night? _____

INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I understand that the Osteopathic Manual Practitioner is providing osteopathic manual therapy within their scope of practice.

I hereby consent to my Osteopathic Manual Practitioner to treat me with Osteopathic manual therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Manual Practitioner.

I understand that treatments include manual therapies where the Osteopathic Manual Practitioner places his/her hands on your body. Many techniques will involve contact between your body and the Osteopathic Manual Practitioner's body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones. If intra-oral work is required, disposable latex or vinyl gloves will be worn.

I understand that the Osteopathic Manual Practitioner may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The techniques can be discontinued or modified to be comfortable for you.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Osteopathic Manual Practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Practitioner and have disclosed to the Osteopathic Manual Practitioner all of those medical conditions affecting me. It is my responsibility to keep the Osteopathic Manual Practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Osteopathic Manual Practitioner to release or obtain information pertaining to my conditions(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Osteopathic Manual Practitioner from time to time, to deal with my physical, emotional, and mental conditions and for which I have sought treatment.

CANCELLATION POLICY

Patients are required to provide **24 hour notice** for any cancellation. That time has been reserved for you and we appreciate having adequate time to fill the spot. The clinic reserves the right to charge the full fee for a missed appointment or an appointment cancelled with less than 24 hour notice.
Thank you for respecting our time. Initial: _____

DATE: _____ **Signature: _____**