

Osteopathy Intake and Consent Form

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ (Bus.): _____ (Cell) _____

E-mail: _____

Date of Birth: _____

Occupation: _____ Primary Complaint: _____

Height: _____ Weight: _____ Blood Pressure: _____ Resting Pulse: _____

Please list presence of any internal pins, wires, artificial joints or special equipment:

Please list any allergies:

Name of Medical Doctor: _____ Phone: _____

- How did you hear about us? Doctor Other Health Practitioner Website Signage
 Word of Mouth Other:

This is a confidential record of your medical history.

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

Would you like your therapist to send a progress report regarding your treatment to your:

- Family Doctor yes no
- Referring Doctor/Practitioner yes no
- Other Practitioner involved in your care yes no

If yes, please provide contact information below

Describe your general health:

Are you receiving treatment from other health care professionals? yes no

If yes, please explain:

Have you ever experienced pain or injury to?

- | | | | |
|------------------------------------|--------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Hips | <input type="checkbox"/> Head | <input type="checkbox"/> Sacroiliac Joints |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Legs | <input type="checkbox"/> Neck | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Knees | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Feet | <input type="checkbox"/> Lower back | |

Briefly provide relevant details:

Bonnie Butler 2504989434

Registered Manual Osteopath

Circle and explain (dates, procedures, etc.) in area 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 or screw in your body?
 - yes no Do you have any children?
- No. of Children _____ No. of C-Sections _____ Are you pregnant now? yes no

Current Medications:

Reason for Taking Medication:

Do you at the present time experience:

- yes no Dizziness, weakness, fainting, vertigo, drop attacks or disorientation?
- yes no Disturbances of vision, speech co-ordination or 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 Difficulty sleeping?
- yes no A significant weight change in the past year?

Have you ever experienced:

- yes no Recurrent ear, throat or sinus infections?
- 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, 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? (please circle/check)

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease/Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Stroke/CVA | <input type="checkbox"/> STD'S |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy (type) | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis (type) |
| _____ | <input type="checkbox"/> Migraines | <input type="checkbox"/> Skin Conditions |
| _____ | <input type="checkbox"/> Headaches (type) | <input type="checkbox"/> Other |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

FAMILY HISTORY: Please identify any problems listed above that have occurred in your immediate family.

(Indicate family members affected)

Ailment: _____ Affected: _____

CLIENT CONSENT TO ASSESSMENT/TREATMENT

Treatments may include manual therapies where the health practitioner places her hands on your body. Many techniques will involve contact between your body and the practitioner's body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones. If intraoral work is required (work inside the mouth), disposable latex or vinyl gloves will be worn.

At times, the practitioners 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 me immediately. The techniques can be discontinued or modified to be comfortable for you.

Consent re: Personal Information and Treatment

I value the trust you have placed in me and I am taking all appropriate measures to safeguard your personal information and confidence. I request that you provide your consent as set out below.

I _____ have informed the Osteopath of all my known physical conditions, mental conditions and medications, and I will keep the Therapist updated on any changes.

I understand that the possible risks and benefits of osteopathy will be explained to me regarding my individual treatment plan and accept responsibility of inform my therapist if I do not understand any aspect of the risks and benefits.

I understand that osteopathy is not a substitute for medical treatment and/or medications, and that it is recommended that I work concurrently with my Primary Caregiver for any conditions I have. I am aware that diagnosing conditions is not part of the osteopath's scope of practice.

I am aware of, and agree to, the fee schedule as presented by Relax Manual Osteopathy.

All information provided by you is strictly confidential and will not be released without written consent except where required law.

DATE: _____

Signature: _____
