Mhairi Fyfe
Registered Osteopath

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?

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

Briefly provide relevant details:

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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)

❒ Diabetes
❒ Cancer
❒ Tumor
❒ Allergies
❒ Heart Disease/Problems
❒ High/Low Blood Pressure
❒ Stroke/CVA
❒ Epilepsy (type
❒ Asthma
❒ Migraines
❒ Headaches (type)
❒ Hepatitis
❒ HIV/AIDS
❒ STD'S
❒ Tuberculosis
❒ Arthritis (type)
❒ Skin Conditions
❒ Other

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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 Natural Path Wellness, Ltd.

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

DATE: _____ Signature: _____

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