Osteopathy Intake and Consent Form

Name: ____ Date: ______________________________

Date of Birth: M_______D______Y________ Preferred Pronoun/s ___________________________

Address: ____

City: _______________________ Province: ________ Postal Code __________

Phone #: (___)__________________ Cell # (___)_________________ Work #: (___)_______________

Employed / Self-Employed / Stay-At-Home Parent / Retired / Student ________________________

Emerg. contact: ____________________________ Relationship: ____________ Phone #: _____________

Email: ____________________________How did you hear about us? ______________________________

Height: ______________ Weight: ____________ BP: _______________ Resting Pulse: ____________

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.

Please list any ALLERGIES: ____

Primary Reason for first visit: ____

____

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:

☐ Head ☐ Neck ☐ Shoulders ☐ Arms/Elbows ☐ Hands ☐ Abdomen

☐ Upper back ☐ Mid back ☐ Lower back ☐ Hip ☐ Pelvic ☐ Leg ☐ Knees ☐ Feet

Briefly provide relevant details: ____

____

Current Medications: Reason for Taking Medication:

_________________________________ ____

_________________________________ ____

_________________________________ ____

_________________________________ ____

yes	no	date	Have you ever been in a car accident?
yes	no	date	Have you ever experienced a hard fall onto your back or buttocks?
yes	no	date	Have you ever experienced a hard blow to your head or a concussion?
yes	no	date	Have you ever had any Surgical procedure?
yes	no	date	Do you have a pin, plate or screw in your body?
yes	no	date	Do you have any children?

No. of Children ____________ No. of C-Sections ______________ Are you pregnant now? ❒Yes ❒No

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.)

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

If yes, please explain: ____

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

____

Do you have any of the following conditions? (please circle/check):

❒Cancer/Tumors ❒Allergies ❒Diabetes, type ______ ❒Epilepsy (type ______________________________)

❒Stroke/CVA ❒Heart Disease/Problems ❒High/Low Blood Pressure

❒Hepatitis ❒HIV/AIDS ❒STD'S ❒Tuberculosis ❒Asthma

❒Arthritis (type ________________________) ❒Migraines ❒Headaches (type _______)

FAMILY HISTORY: Please identify any problems listed above that have occurred in your immediate family. (Indicate family members affected)

Ailment:	Family Member 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, 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 massage 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: ____