Action Health

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Osteopathy Intake and Consent

Name: _____ Preferred Name: _____

Date of Birth (MM/DD/YYYY): _____ Gender: ❑ Female ❑ Male ❑ Other

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

How did you hear about our office? _____

Occupation: _____

Employer's Address (if known): _____

Is this injury the result of a work-related accident or a motor vehicle accident? ❑ Yes ❑ No

If yes, please give the date of the accident: _____

What is your major complaint / reason for coming into our office?

_____

Family Doctor's Name: _____ Phone Number: _____

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

_____

Please list any allergies: _____

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

Family Doctor ❑ Yes ❑ No

Referring Doctor ❑ Yes ❑ No

Other practitioner involved in your care ❑ Yes ❑ No

If yes, please provide contact information below:

_____

_____

_____

Describe your general health: _____

_____

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

Are you receiving care from other health care practitioners? ❑ Yes ❑ No

If yes, please explain: _____

Have you ever experienced pain or injury to:

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

Briefly describe relevant details: _____

_____

Please check any that apply and briefly explain below:

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 had a concussion? ❑ Yes ❑ No

Have you ever had any spinal surgery? ❑ Yes ❑ No

Do you have a pin, plate, or screw in your body? ❑ Yes ❑ No

Do you have children? ❑ Yes ❑ No

No. of children _____ No. of C-Sections _____ Are you pregnant now? ❑ Yes ❑ No

_____

_____

_____

Please list all current Medications and reasons for taking: _____

_____

_____

_____

_____

Please check all that you are currently experiencing:

- ❑ Dizziness, weakness, fainting, vertigo, drop attacks, or disorientation
- ❑ Disturbances of vision, speech, co-ordination or balance, or difficulty swallowing
- ❑ Numbness or pins and needles in any part of your body.
  Where? _____
- ❑ Difficulty with bowel or bladder function
- ❑ Cough, shortness of breath, chest pain, or palpitations
- ❑ Poor appetite, nausea, or vomiting
- ❑ Difficulty sleeping
- ❑ A significant weight change in the past year

Please check any that have ever experienced:

- ❑ Recurrent ear, throat, or sinus infections
- ❑ Respiratory disease or disorder (ie. asthma, pneumonia, bronchitis, etc.)
- ❑ Stomach, intestinal, or any digestive problems
- ❑ Bladder or kidney problems (ie. infection, disease, etc.)
- ❑ Gynecological conditions (ie. endometriosis, cysts, fibroids, etc.)

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

If yes, please explain: _____

_____

Do you have any of the following conditions?

- ❑ Diabetes (type) _____
- ❑ Cancer (type) _____
- ❑ 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
  _____
  _____
  _____

Family History: Please identify any problems listed above that have occurred in your immediate family. (Indicate which family member was 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 your practitioner 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 to 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 Action Health.

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

Printed Name: _____

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____