OSTEOPATH INTAKE AND RELEASE FORM

Personal Information: Date: _____

First Name: _____ Last Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Telephone: Home: _____ Cell: _____

Work: _____ Alberta Health Care Number: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____Sex: _____

Occupation: _____

E-mail: _____

Phone Call Reminders: ☐ Email Reminders:☐ None: ☐

How did you hear about us? _____

Emergency Contact Information: Name: _____ Phone: _____

How did you hear about the Balanced Health and Sports Therapy? _____

ARE YOU CURRENTLY TAKING MEDICATION: YES ☐ NO ☐

If **YES** LIST ALL MEDICATIONS AND WHAT CONDITION THEY ARE FOR:

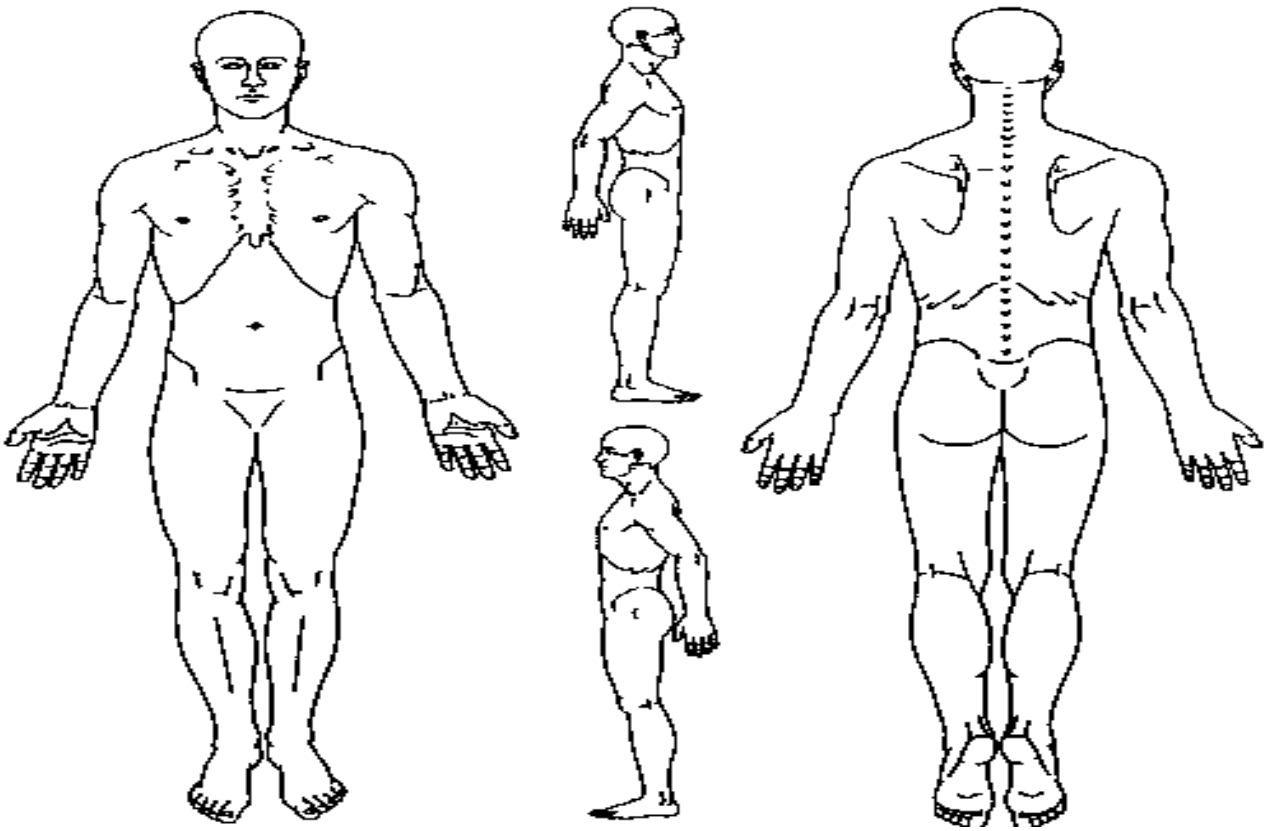
_____

_____

Are you receiving any other therapies or treatments: YES☐ NO☐

If YES please describe: _____

Please mark the areas you feel any pain or discomfort:



Purpose for Visit

Primary Complaint:_____ Date of Onset: _____

How did it happen: _____

Imaging Studies (X-ray, MRI, etc): _____

Previous Treatment(s) and Type: _____

Past Medical History

Please check if you are currently or have experienced any of the following conditions

General

- ☐ Headache (Frequently)
- ☐ Migraines
- ☐ Jaw Pain/Clicks
- ☐ Clenching
- ☐ Orthodontics
- ☐ Major Dental Work Done
- ☐ Cancer (Type:_____)

Ears/Eyes/Nose/Throat

- ☐ Vision Issues
- ☐ Glasses/contacts
- ☐ Eye surgery
- ☐ Ear infection/aches
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Sinus infections/problems
- ☐ Deviated septum
- ☐ Recurrent sore throat

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Seasonal allergies
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Chronic bronchitis
- ☐ Colds (Frequency: _____)

Gastrointestinal

- ☐ Gall bladder trouble
- ☐ Gas/burping
- ☐ Constipation
- ☐ Rectal pain
- ☐ Indigestion/acid reflux
- ☐ Nausea/vomiting
- ☐ Liver issues
- ☐ Diarrhea

Bones/Muscles/Joints

- ☐ Neck
- ☐ Shoulders (L) (R)
- ☐ Elbows (L) (R)
- ☐ Wrist (L) (R)
- ☐ Hands (L) (R)
- ☐ Upper Back
- ☐ Middle Back
- ☐ Low Back
- ☐ Hips (L) (R)
- ☐ Knees (L) (R)
- ☐ Ankles (L) (R)
- ☐ Feet (L) (R)
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteopenia/Osteoporosis
- ☐ Fibromyalgia
- ☐ Chronic Pain

Cardiovascular

- ☐ High blood pressure
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Fainting
- ☐ Low blood pressure
- ☐ Stroke/CVA
- ☐ Heart attack (Date: _____)
- ☐ Irregular heartbeat
- ☐ Swelling of limbs
- ☐ Congestive heart failure

Endocrine

- ☐ Thyroid (Hyper/Hypo) (circle one)
- ☐ Low energy
- ☐ Diabetes (Type:____; Onset:_____)

Reproductive

- ☐ Fertility issues
- ☐ Prostate problems

☐ Blood in stool ☐ Food allergies ☐ Weight gain ☐ Weight loss ☐ Abdominal cramping ☐ Hemorrhoids ☐ Irritable bowel syndrome <u>Neurological</u> ☐ Numbness/tingling ☐ Seizures/epilepsy ☐ Poor memory ☐ Concussion ☐ Multiple sclerosis (MS) ☐ Loss of balance ☐ Decreased coordination	☐ Menstrual issues ☐ Ovarian cists ☐ Fibroids ☐ Menopausal ☐ Pregnancies: o # of Pregnancies:_____. o # of Births:_____. o # of Miscarriages:_____, <u>Urinary</u> ☐ Bladder infections ☐ Kidney infections ☐ Kidney stones

PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF VISIT.

Please note our cancellation policy: If less than 24 hours' notice is given to cancel your appointment, your account will be charged the full price of the appointment.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.

_____ _____

SIGNATURE of Patient (or parent/guardian) **DATE**

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.

_____ _____

SIGNATURE of Patient (or parent/guardian) **Date**