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OSTEOPATHY PATIENT INTAKE FORM

First Name: _____ Last Name: _____

Address: _____
 City: _____ Province: _____ Postal Code: _____

Telephone (C): _____ (H): _____
 (W): _____

Email address: _____

Date of birth: _____ I identify my gender as: _____

Occupation: _____

Emergency Contact _____
 (Full name) (Relation) (Telephone)

How did you hear about the clinic? _____

Do you have a Family Physician: yes no

Name of Family Physician: _____

Reason for treatment: _____

Please select the conditions that you are currently experiencing or have experienced in the past

<u>Soft Tissue/ Joints</u>	<u>Head Trauma</u>	<u>Respiratory</u>
<ul style="list-style-type: none"> <input type="radio"/> Neck <input type="radio"/> Shoulder <input type="radio"/> Upper back <input type="radio"/> Mid back <input type="radio"/> Low back <input type="radio"/> Arms <input type="radio"/> Chest <input type="radio"/> Legs <input type="radio"/> Knees <input type="radio"/> Hips <input type="radio"/> Feet <input type="radio"/> Hands <input type="radio"/> Face Other: _____ 	<ul style="list-style-type: none"> <input type="radio"/> Migraines <input type="radio"/> Concussion <input type="radio"/> Tension headaches <input type="radio"/> Aneurysm Other: _____ 	<ul style="list-style-type: none"> <input type="radio"/> Chronic cough <input type="radio"/> Shortness of breath <input type="radio"/> Bronchitis <input type="radio"/> Asthma <input type="radio"/> Emphysema <input type="radio"/> Pneumonia <input type="radio"/> Sinus problems Other: _____

<p align="center"><u>Accident/ Injury</u></p> <ul style="list-style-type: none"> ○ Motor vehicle ○ Work related ○ Other: _____ ○ Date: _____ ○ Symptoms: _____ <p>Physical Limitations: _____</p>	<p align="center"><u>Infectious Disease</u></p> <ul style="list-style-type: none"> ○ Hepatitis ○ Infectious skin conditions ○ Tuberculosis ○ HIV <p>Other: _____</p>	<p align="center"><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> ○ Irritable Bowel Syndrome ○ Crohn's Disease ○ Constipation ○ Diarrhea <p>Other: _____</p>
<p align="center"><u>Cardiovascular</u></p> <ul style="list-style-type: none"> ○ High blood pressure ○ Low blood pressure ○ Heart attack ○ Pacemaker ○ Phlebitis/ Deep Vein Thrombosis ○ Stroke/ Cerebrovascular accident ○ Pulmonary Embolism ○ Heart Disease ○ Angina ○ Chronic congestive heart failure <p>Other: _____</p>	<p align="center"><u>Skin</u></p> <ul style="list-style-type: none"> ○ Bruise easily ○ Herpes ○ Varicose veins ○ Loss of sensation <p>Other: _____</p>	<p align="center"><u>Pelvic Conditions</u></p> <ul style="list-style-type: none"> ○ Pelvic pain ○ Pelvic floor prolapse ○ Polycystic Ovarian Syndrome ○ Prostate issues <p>Other: _____</p> <hr/> <p><u>If pregnant</u> How far along: _____ Due date: _____</p>
<p align="center"><u>Kidney/ Bladder</u></p> <ul style="list-style-type: none"> ○ Urinary incontinence ○ Bladder infections ○ Kidney stones <p>Other: _____</p>	<p align="center"><u>Other conditions</u></p> <ul style="list-style-type: none"> ○ Neurological conditions ○ Epilepsy ○ Diabetes ○ Cancer ○ Arthritis ○ Insomnia ○ Depression ○ Anxiety ○ Multiple Sclerosis <p>Other: _____</p>	<p align="center"><u>Paediatric Population</u></p> <ul style="list-style-type: none"> ○ Ear infection ○ Trouble sleeping ○ Difficulty feeding ○ Colic ○ Plagiocephaly <p>Other: _____</p>

Current Medications and Conditions:

Surgeries

Type: _____

Date: _____

Current symptoms:

Any pins/ wires or prosthetics? ○ yes ○ no

Lifestyle habits/ activities of daily living:

Patient non-discrimination Policy

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

Initials: _____

Lateness Policy

Clients are responsible for the time they reserve for their appointment. If you are late for your appointment, the appointment will still finish at the designated time.

Initials: _____

Cancellation Policy

When you book an appointment with a therapist, you are booking that therapists` time. In order to accommodate all our clientele, we need 24 hours notice preceding the scheduled appointment time of any cancellations and/ or rescheduling, so that we can offer your appointment time to others. If you are unable to make the appointment, we request that you notify us 24 hours in advance. If you do not call to cancel and /or reschedule before the 24 hour period, the full treatment charge will apply.

Initials: _____