HOLISTIC WELLNESS OTTAWA

Osteopathy Intake

Name: _____ ◯ Female ◯ Male Birth Date: _____

Primary Care Physician - name and address: _____

_____ May we contact them? ◯ Yes ◯ No

Reason for appointment: _____

When did this begin? _____

Have you ever had similar problems? ☐ Yes ☐ No What?: _____

How did this occur? _____

Is this condition related to: **Work**? ◯ Yes ◯ No **Has your employer been notified**? ◯ Yes ◯ No

Motor Vehicle Accident? ◯ Yes ◯ No Date of Injury:

Since it began has the condition ◯ improved ◯ worsened ◯ unchanged

What have you done for this condition? _____

Have you had X-rays, MRI or other tests for this condition? What tests and when? (Please bring any reports / scans / X-rays etc)

_____

_____

What do you hope to achieve from this visit? Check all that apply.

☐ Pain relief ☐ Explanation of your condition ☐ Exercises to prevent recurrence ☐ Temporary relief ☐ Lasting corrective care

Please explain: _____

_____

Circle the word that best describes the way you feel about your <u>general health</u>:

excellent ☐ good ☐ acceptable ☐ uneasy ☐ concerned ☐ very concerned ☐

frustrated ☐ pained ☐ frightened ☐ distressed ☐ unbearable ☐

Have you recently experienced a major upset in your life? ☐ Yes ☐ No **Explain**: _____

_____

Have you or a family member ever been diagnosed or told you have any of the following? Please check the appropriate box.

High Blood Pressure	◯ Yes	◯ No	◯ Family_____
Hardening of the arteries	◯ Yes	◯ No	◯ Family_____
Diabetes	◯ Yes	◯ No	◯ Family_____
Tuberculosis	◯ Yes	◯ No	◯ Family_____
Cancer, where?	◯ Yes	◯ No	◯ Family_____
Heart or blood disease	◯ Yes	◯ No	◯ Family_____
Stroke	◯ Yes	◯ No	◯ Family_____
Osteoporosis	◯ Yes	◯ No	◯ Family_____

Bone spurs on neck bones ◯ Yes ◯ No **Whiplash injury** (flexion-extension injury, cervical sprain) ◯ Yes ◯ No

Were you ever a smoker? ◯ Yes ◯ No From_____ to_____

Visual disturbances (blurring, loss, double)	◯ Yes	◯ No
Hearing disturbances (loss, ringing, other noise)	◯ Yes	◯ No
Slurred speech or other speech problems	◯ Yes	◯ No
Difficulty swallowing	◯ Yes	◯ No
Dizziness	◯ Yes	◯ No
Loss of consciousness, even momentary blackouts	◯ Yes	◯ No
Sudden collapse without loss of consciousness	◯ Yes	◯ No

Numbness, loss of sensation, strength or weakness in face, fingers, hands, arms, legs, or other parts of the body ◯ Yes ◯ No

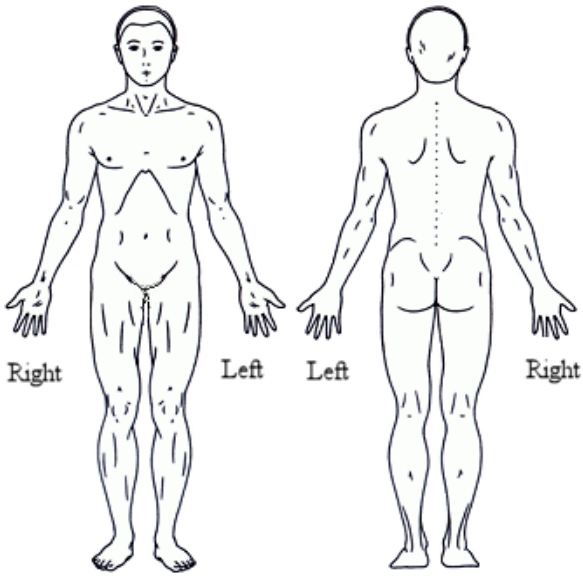
Using symbols below, mark on body diagram:

X = Pain

O = Numbness

Z = Tingling

/ = Other_____



On a scale of 1 (mild) – 10 (extreme),
how would you rate your pain level today? _____

Informed Consent to Treatment

I understand that the osteopathic manual practitioners at Ottawa Holistic Wellness utilise the principles and practices of Osteopathy, a natural medicine which aims to restore function in the body by treating the causes of pain and imbalance. This treatment is based on Osteopathic manual practice and may contain some or all of the following: gentle mobilization of the joints, muscles, connective tissue, fluids, viscera and nerve pathways. It combines different manual techniques based on the principles of Osteopathic diagnosis and treatment, including advice on posture and exercises within the Osteopathic scope.

I understand that the treatment and advice provided by the practitioner is not in place of, or to the exclusion of, any other treatment or advice that I am now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner.

I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

It is my responsibility to inform my practitioner of any pre-existing medical conditions, injuries or disease, and to inform the practitioner of any changes in my condition during the course of treatment.

I understand that at times my practitioner may request that I remove outer clothing, retaining my underwear, in order to facilitate the most effective treatment and that it is my choice as to whether I do this. It is my responsibility to inform my practitioner if I am not comfortable removing this clothing.

I understand that my practitioner reserves the right to discontinue services where it is apparent that my expectations and the type of services provided are not compatible.

I understand that a confidential record will be kept of the health services provided to me and that I may view my records at any time.

I understand that results are not guaranteed. I do not expect my practitioner to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Osteopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name _____ Guardian Name: _____

Patient / Guardian Signature_____ Date: _____

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