

Osteopathy Intake

Name: _____

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 general health:

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

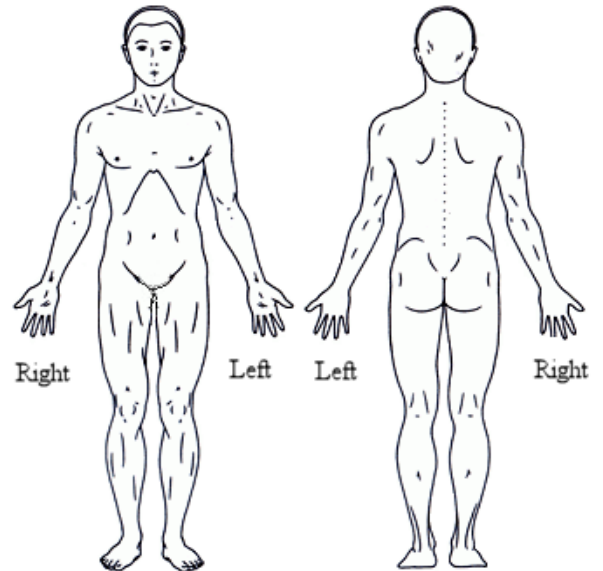
Using symbols below, mark on body diagram:

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: _____