Osteopathic Health History Questionnaire

Patient Name: _____ Daytime Telephone Number: _____

Date of Birth: _____ Email address: _____

Home adress: _____

Family physician name & complete address: _____

Name of Insurance Provider: _____

General Information

Occupation and description job related activities:_____

Are you currently seeing a: Physician / Chiropractor / Physiotherapist / Massage therapist / Other:_____

Date of last consultation with any of the above practitioners: _____

Do you wear orthodics or a prosthesis? Yes / No _____

Have you had any medical imaging tests? X-rays / MRIs / CT Scans / Blood tests / Ultrasound _____

When were the tests done & what were the test results? _____

_____

What medications do you currently take? _____

What natural supplements do you currently take? _____

Please describe your sleeping habits: _____

Please describe your eating habits/diet: _____

Please describe your exercise/activities/sports: _____

Have you has any earlier related or unrelated injuries or trauma, motor vehicle accidents, injuries at work, sports, ect?

_____

_____

What is your main reason for seeking osteopathic treatment? (please provide a clear answer)

_____

_____

Past Medical History

___ osteoporosis
___ osteoarthritis
___ rheumatoid
___arthritis
___ gout
___ high cholesterol
___ high blood pressure
___headaches/migraine

___ heart disease
___ ulcers
___ urinary infection
___ immune disorders
___ insomnia
___blood clots
___ glaucoma
___hepatitis

___eczema / hives
___ liver disease
___thyroid disease
___ anemia
___bleeding disorder
___diabetes
___ stroke / aneurism
___ seizures

___ asthma
___depression
___ pneumonia
___gall / kidney stones
___ Anxiety / nerves
___ Pregnacy
___Menopause
Other please specify:

Past Surgical History

__tonsils
__adenoids
__appendix
__uterus
__tooth extraction
__ovaries
__eye
__neck
__chest
__skin excision
__abdomen
__gallbladder
__bowel
__breast
__circumcision
__bunions
__fractures
__stitches

Check off any of the following symptoms you have experienced in the past 6 months

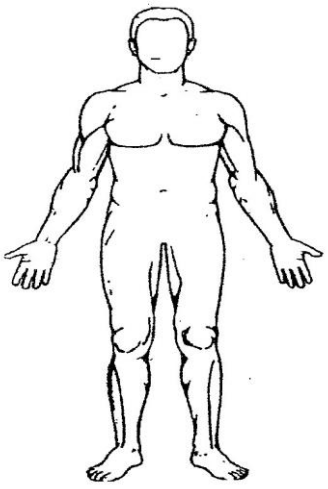
□ Headaches / Migraine
□ Pain Between Shoulder Blades
□ Knee Pain
□ Ankle/Foot Pain
□ Wrist/Hand Pain
□ Elbow Pain / Shoulder pain
□ Hip Pain
□ Numbness/Tingling in Arms/Hands
□ Numbness/Tingling in Legs/Feet
□ Loss of Grip Strength
□ Work Related Injury
□ Automobile Accident Injury
□ Tension Across Top of Shoulders
□ Carpal Tunnel
□ Low Back Pain/Sciatica
□ Neck Pain
□ Burning in Arms/Legs
□ Cold Feeling in Arms/Legs

Do you experience:

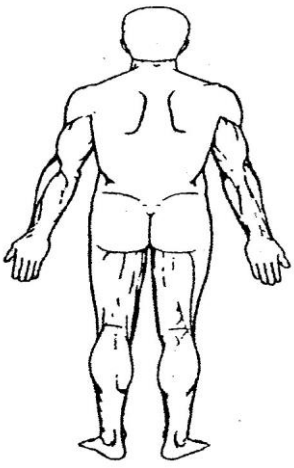
□ Fatigue
□ Difficulty Sleeping
□ Ringing in Ears
□ Nervousness
□ Dizziness
□ Digestive Disturbances
□ Depression
□ Anxiety
□ Painful/Frequent Urination
□ Heartburn
□ Constipation
□ Diarrhea
□ Other please specify:

_____

Mark lines (////) where you have numbness/tingling.



Mark circles (oooo) where you have pain.



Please add any further comments regarding your present symptoms :

_____

_____

_____

INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I understand that the Osteopathic Manual Practitioner is providing osteopathic manual therapy services 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, as recommended.

I acknowledge that the Osteopathic Manual Practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual therapy is not a substitute for a medical examination. I understand that it might be recommended that I attend my personal physician for any ailments that I may be experiencing. 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.

Some Clinic Procedures and What You Need to Know:

Proper Clothing: Please bring shorts, yoga pants, and t-shirt or camisole to change into for your physical assessment. Osteopathic Treatments cannot be properly performed in street clothes. Gowns can be provided if necessary.

If you are a new patient, please ensure to arrive minimum 15 mins in advance to fill out the Osteopathy Health History Form prior to your scheduled appointment.

Also, please bring copies any medical imaging test results related to your condition. Original CDs of medical imaging will have to be left at the clinic for viewing outside of your allotted consultation time.

Out of respect for scheduling, please inform the Osteopath if you have an appointment with another therapist at the clinic immediately after your Osteopathic appointment.

Please provide minimum 24 hrs notice to re-schedule any appointment. Missed appointments without adequate prior notice will be charged the full amount of the consultation.

By completing and signing this Informed Consent and Health History Questionnaire, I acknowledge that I have read the above noted consent and I have had the opportunity to question the contents and my therapy. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient signature: _____ Date:_____