Classical Osteopathy

Please complete this Health History form as accurately as possible. These forms will help to ensure that you receive a safe and effective treatment. If at any time your health status changes, please let us know as soon as possible prior to your next treatment. All information is strictly confidential and cannot be released to anyone without your written consent. If at any time you have any questions, feel free to ask.

Client Name: ____

Address: ____

City: ______________________ Postal Code: ______________________

Phone (Home/Cell): ________________ Phone (Work): ________________

E-Mail: ____

Age: _____ Date of Birth: ________________ Height: ________ Weight: ________

Occupation: ____

Family Physician: ______________________ Phone: ______________________

Emergency Contact: ______________________ Phone: ______________________

Reason for Treatment: ____

How did you hear about us? ____

Do you have Extended Health Care/Group Insurance Benefits for Osteopathy?

YES / NO

HEALTH HISTORY

Head/Neck
- O Headaches
- O Dizziness
- O Earaches
- O Sinus (Pain/Congestion)
- O Neck Pain

Muscle/Joints
- O Pain
- O Stiffness
- O Swelling
- O Limited Range of Motion
- O Fatigue
- O Osteoarthritis
- O Rheumatoid Arthritis
- O Back Pain (Upper/Middle/Low)
- O Shoulder Pain
- O Hip Joint Pain

Women- Menstruation
- O Painful
- O Heavy
- O Light
- O Normal
- O Irregular
- O Absent
- O Pregnant (Weeks: __________)
- O Children (# ________)
- O Menopause
- O Hysterectomy (Date: ________)

Respiratory Health
- O Asthma
- O Bronchitis
- O Emphysema
- O Shortness of Breath
- O Chronic Cough
- O Difficulty Breathing During Sleep

Allergies
- O Seasonal
- O Food (Specify: ____________________)
- O Medication (Specify: _______________)
- O Other

Specify: ___________________________

Skin
- O Sensitive Skin
- O Rashes
- O Acne
- O Cold Sores
- O Bruise Easily
- O Varicose Veins
- O Eczema/Psoriasis
- O Recent Tattoos/Piercings/Stitches

Location: ______________________

Cardiovascular Health
- O High / Low Blood Pressure
- O Poor Circulation (Cold Hands/Feet)
- O Heart Disease
- O High Cholesterol
- O Pacemaker
- O Stroke

Digestive Health
- O Poor Digestion /Acid Reflux
- O Irritable Bowel Syndrome
- O Diarrhea
- O Constipation
- O Liver/Gallbladder
- O Kidneys/Bladder
- O Stones in Kidney/Gallbladder

Previous Health Care
- O Massage Therapy
- O Osteopathy
- O Acupuncture
- O Physiotherapy
- O Chiropractic
- O Psychotherapy
- O Other

Specify: ___________________

Family History:

____

Current Medications
- O Prescriptions

List: _____________________

____

____

____

General Health
- O Good
- O Average
- O Poor

General Stress Levels
- O High
- O Moderate
- O Low

Diet
- O Regular Meals
- O Irregular Eating Habits
- O Specialized Diet
- O Caffeine
- O Smoking

If yes, packages per day? ______

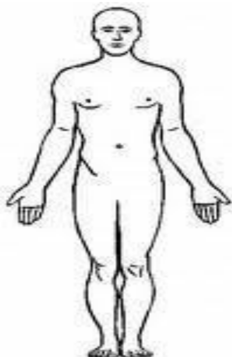
Exercise
- O Regular
- O Occasional
- O Moderate
- O Little
- O None

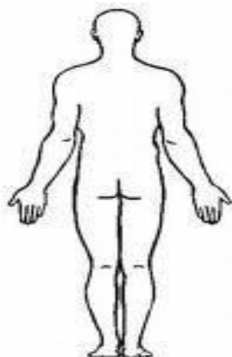
Other
- O Vision Problems
- O Vertigo
- O Disc Herniation/Prolapse
- O Hearing Loss
- O Ear (Infections, Ringing, etc.)
- O Hepatitis (Type: ___________)
- O HIV
- O Tuberculosis (TB)

Vitamins/Herbal Product
- O Vitamins/Minerals
- O Herbal Teas
- O Other

Specify: _______________________

PLEASE USE THIS DIAGRAM AND CIRCLE ANY AND ALL AREAS OF DISCOMFORT/PAIN.





Accident/Injury/Trauma History
Date: ________________ Details: ________________________________

Date: ________________ Details: ________________________________

Surgery
Date: ____________________________

Reason: __________________________

Date: ____________________________

Reason: __________________________

Date: ____________________________

Reason: __________________________

Date of Last Physical
Day: _____ Month: __________

Year: ___________

Special Notes:
- O Walker
- O Cane
- O Prosthetics
- O Other (Specify: ___________)

๑ OFFICE POLICIES & PROCEDURES ๑

It is strongly recommended that you fully read and understand the clinic policies and procedures. If you have any questions, please ask. In signing this form, you are fully aware and agree to all terms and conditions outlined in this document. Treatments are not intended for substituting primary medical care. Always check with your primary family physician before implementing alternative/complimentary forms of healthcare. In signing, you agree that you have reported all your health history to the practitioner, as well as your family physician. Report any changes to your health to your family physician immediately.

- ☑ Patient information recorded on health history forms is important to give you the most safe and effective treatment. In becoming a client/patient of this clinic, it is understood that all information discussed or recorded is strictly confidential and may not be released without your written consent. Therapists do not share files; therefore, if you choose to be treated by another therapist, a new health history/consent form must be filled out. The therapists working in this clinic setting are independent. They do not represent one another and are not legally responsible for one another.
- ☑ New patients must fill out a health history form and consent form. A full assessment is performed on your first visit so that a relevant treatment plan may be set up for you. New health history forms must be filled out after a long duration away from treatment, or when seeing any new therapist in the clinic for the first time, and/or if your health history changes dramatically.
- ☑ The clinic is therapeutically based and follows the strict guidelines of the RHPA and OOA. If at any time you are uncomfortable and wish to alter the treatment plan or application of treatment, please feel free to discuss it with your therapist, so that your needs can be fully addressed in a timely manner. If you require alternative therapy, an alternate therapist will be located for you.
- ☑ Payments can be made in either CHEQUE, CASH or E-transfer and a receipt will be issued. Please photocopy your receipt prior to sending it to your insurance provider as they may sometimes get lost in the mail/courier services. Re-issue of receipts will be at cost. If you require a full list of treatment dates at the end of the year, one will be provided for a fee of $100. Returned cheques (Non-Sufficient Funds-NSF) will be subject to a $35 service fee.
- ☑ Due to the lack of secretarial staffing, reminder calls are not office policy; however, an appointment card will be issued. **Please be considerate and give a 48-Hour notice if you cannot make your appointment so other patients may receive treatment in your place. Changes to scheduled appointments less than 48 hours are considered a full charge, unless it is a true emergency, sudden severe illness or unavoidable circumstance. Missed appointments without notification/No-shows will be issued a full charge of the time scheduled, except in the event of extreme illness or emergency or unavoidable circumstances.**
- ☑ If you are late for your appointment, it is understood that only the time remaining is allotted for your treatment, unless additional time is available for your therapist. Please be considerate and be on time.
- ☑ Upon arrival to the clinic, please remove your shoes, help yourself to slippers and have a seat in the waiting room. **Please do not call out or knock on the therapists' rooms as treatments will be in session. Please do not bring food/drinks into the clinic**. Do not consume alcohol or energy drinks prior to coming to treatment. If the client/patient is under the influence of alcohol/drugs, treatment will be immediately terminated and re-booked to another date with full charge of allotted time implemented.
- ☑ In signing this document, you are giving full consent to assessment & treatment on this date and for any treatments that may follow. You are aware that you are taking on responsibility for any of the effects that may take place during or following the treatment today or in the future. In signing this document, you also agree to all the terms and policies at this office and have disclosed all information throughout the health history form that could possibly have an effect on your treatment outcome, including medications and any other form of treatment (medical/alternative/complimentary) you are having currently or have had in the past.
- ☑ It is **NOT** the policy of this clinic to work through WSIB or MVA claims, however if you require such claims, a therapist in the area will be suggested to you. We DO NOT give letters, documents, notes in WSIB or MVA cases.
- ☑ Clients under the age of 18 must have a parental or legal guardian accompanying them for the initial assessment/treatment. If under the age 16, a parent or legal guardian must be present for all assessments and treatments.

Patient Name: ________________________ Signature: ___________________________ Date: _____________________

CONSENT TO TREATMENT

I, _________________________, of my own free will, consent to be assessed and treated for my conditions by the therapist.

I acknowledge that my therapist has provided me with such information as is pertinent to the treatment for my condition. Alternative course of treatment (where applicable and relevant) have been explained to me, as well as the possible benefits, risks and side effects, if any, with regard to my therapist's proposed treatment plan.

I acknowledge that I have fully disclosed all medical history, including what medications I am currently taking.

I feel that I fully understand what is involved in the proposed treatment plan and what the possible consequences of not having the treatment may be.

I understand that, for the purpose of the integrated therapy, the following areas may be addressed during the course of a treatment: head, neck, shoulders, upper chest, arms, back, hips, abdomen, buttocks, legs, hands, feet, (breast tissue is excluded unless specifically indicated for clinical reason, in which case a separate form will be issued).

I understand that I can exclude any body part I choose to from the treatment.

I understand I may change my mind regarding any aspects of my treatment at any time and upon informing my therapist of my decision, I may withdraw consent with the intent to alter or discontinue the treatment.

In compliance with the "Consent of Treatment Act" (Bill 109), I provide my full, voluntary informed consent to treatment. I intend this consent to pertain to my entire course of treatment.

Date: ___________________________

Client/Patient Signature: ______________________________

Therapist/Practitioner Signature: ___________________________

Cancellation/Rescheduling Policy

(Please read carefully, sign and date at the bottom & respect the practitioner's policy)

I, ___________________________, acknowledge that I must give a minimum of 48 hours notice (this does not include weekends or statutory holidays) in the event I need to change my scheduled appointment, so that other patients in need may receive treatment in my place.

I understand that any missed appointments **without notice** (ie. forgetting, smartphone reminder didn't go off, forgot to put in calendar, forgot you had previous appointment for something else, etc.) will be issued a full charge for the treatment time scheduled.

I understand that appointments cancelled with **less than 48 hours notice** will be charged for the full treatment time scheduled, with the exception of emergencies, severe illness or unavoidable circumstance (severe weather, etc).

I understand that the practitioner is self-employed and last minute cancellations without proper notice affects their value of time at the office. I understand that this allotted time has been designated for me and cannot be easily transferred to another patient with insufficient notice.

We appreciate your understanding and mutual respect, and we look forward to seeing you at your next appointment!

Print Name : ____________________________
Signature : ______________________________
Date : __________________________________

"We live in a society where mutual respect and appreciation should be considered one of the pillars of modern life." ~ Auliq Ice