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Patient Intake Form

Name____

Address____

City ________________________________postal code ________________________

Phone (home)__________________________(cell)___________________________

Work _________________________________ e-mail ___________________________

Date of birth ____

Occupation __________________________emergency (name)____________________

Phone number ________________________relation___________________________

Medical doctor: name _____________________phone number___________________

Are you presently under the care of?

Doctor__ chiropractor__ physiotherapist__ massage therapist__ acupuncture_

Others:____

Last medical exam: ____

Reasons to seek osteopathic care. Main concerns?

Others: ____

Have you consulted a doctor about this? Yes__ no __

What was the diagnostic? ____

Your pain is: constant __ occasional __ progressive__

During the day __ at night __ by times __ in the morning__

Do you sleep well? Yes __ no __

What is your level of energy? 10 being really good: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

List any surgery:___

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Accidents:

___

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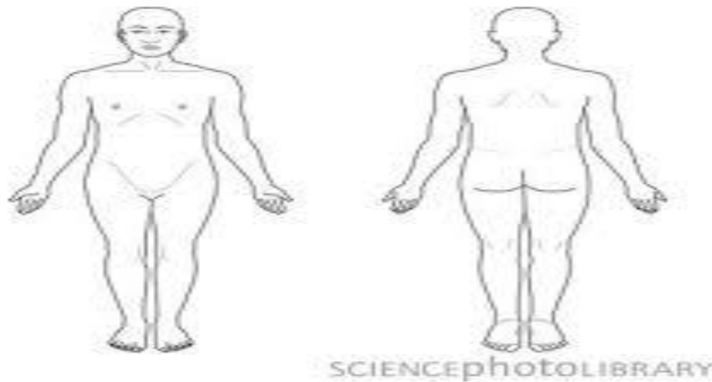
Please, indicate on the figures below the location of your pain



Prescription drugs

Indicate with a "**C**" if you currently experience any of these below, and **"P"** if you did in the past:

Gastrointestinal:

Heartburn / indigestion __ ulcers __ irritable bowels __

Hypoglycemia___ bloating __ flatulence__

Colitis __ Crohn's disease __ acid reflux __

Diarrhea__ hernia (hiatal, umbilical, inguinal) __

Liver disease__ hiatal hernia__ constipation__

Abdominal cramps__ pancreas__ hemorrhoids__

Others ___

Head and neck:

Headaches__ migraines__ head injury__

Dry eyes__ sinus problems__ cervical herniated disc__

Jaw /TMJ __ earaches__ ear infection__

Ringing in ears__ laryngitis__

Others____________________

Cardiovascular and neurological

Stroke/ cardiovascular accident__ explain: ____________________

High blood pressure__ low blood pressure__ High cholesterol___ phlebitis__

Congestive heart failure__ depression__

Myocardial infarction__ Irregular heartbeat__ dizziness__

Chest pain__ cold hands and feet__ angina__ anxiety_

Others ____________________

Muscle, bone and joint:

Broken bone (s) __ bursitis__ osteoporosis__ Joint pain__

Tendinitis__ sciatica ___ low back pain ___ Scoliosis __

Joint swelling__ Rheumatoid arthritis__ herniated disk__

Others ____________________

Respiratory system:

Asthma__ chronic cough__ pain in breathing__

Chronic mucus/phlegm__ Bronchitis__ pneumonia__

Difficulty breathing in inspiration__ in expiration __

Others ____________________

Female:

Sexual dysfunction __ PMS__ painful cycles __

Yeast infection__ abortion__ pain during intercourse__

Ovarian cysts__ breast pain__ Endometriosis__

Vaginitis__ fibroids__ fibrocystic breast __

Are you pregnant? ___ How many pregnancies? (#) ___

Others ____________________

Male:

Andropause __ hernia __ testicular pain__

Prostate enlargement__ prostatitis__ painful intercourse __

Sexual difficulties__ inguinal pain __

Others:____________________

Urinary system:

Frequent urination urgency to urinate__ pain__
Incontinence__ kidney stones__ Kidney infection__

Skin and hair:

Rash __ warts__ rarely perspire__
Sweating too much ___ eczema__ hives__
Psoriasis__
Have you had any skin conditions/ lesions removed or biopsied? yes /no

Infections:

Hepatitis __ tuberculosis__ HIV/aids__
Others:____

Endocrine

Hypothyroidism ___ hyperthyroidism __ diabetic ___
Goiter ___ adrenal disorders ___
Others ____
Cancer, explain:____

____

WRITTEN CONSENT

- All information registered on the Intake Health Form are important in order to offer you a secure and helpful osteopathic care.
- I understand that Manual Practice of Osteopathy does not replace my physician and my physician's diagnostic. I recognize that I must seek my doctor responsible for my medical Health Care and diagnostics.
- The osteopathic approach by the practitioner is discussed before the treatment and consent was given as well verbally.
- I am aware that it is possible and normal to have discomfort from the treatment such as muscle aches or soreness or fatigue. Nevertheless, if it persists over 48 hours, I should call the office to speak to my osteopath.
- I understand and give my consent for manual practice of osteopathy that may cover regions like the upper thorax, sternum (chest), the pelvis, and sometimes the pelvic floor and the muscles of the buttock. I hereby understand that at any time during the session I may stop and reverse my consent to the treatment, or to a technique, or to a region of my body.
- **I understand that if I am late for my treatment, I will receive the remaining time of my session. If I do not call to cancel an appointment, I will be responsible to pay a compensation of $110. I accept to give 24hours notice.**

- ❖ Patients under 16 years old must be accompanied by a parent or legal guardian for initial treatment and must co-sign this document. If a patient is under 16, a parent or legal guardian must be present for all treatments.
- ❖ Once I have filled out the Intake Health Form, I confirm that all given information is true and complete. None of my information of my file will be communicated unless I give written authorization. When I give a written permission to share my file, I understand that it includes the Intake Heath Form, charts, session's note and correspondence.
- ❖ I have stated all medical conditions I am aware of and will provide an update of any changes in my health status.

Signature: ____Date:____________________

Signature of parent/ gradient ____

Date: ____