New Hamburg Wellness Centre
OSTEOPATHY PATIENT INTAKE FORM

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE NUMBER: (HOME) _____ (WORK) _____ EXT. _____

(CELL) _____ EMAIL ADDRESS: _____

DATE OF BIRTH: M_____D_____Y_____ OCCUPATION: _____

WHERE DID YOU HEAR ABOUT US? _____

MEDICAL DOCTOR: _____ PHONE NUMBER: _____

OTHER HEALTH CARE? □ Chiropractic □ Naturopathic □ Physiotherapy
□ Other, *please explain* _____

PRESENT COMPLAINT _____

How long have you had this condition? _____

What aggravates this condition? _____

HEALTH HISTORY QUESTIONNAIRE

Please check all current and past conditions.

MUSCLE
□ pain □ stiffness □ tear □ shoulder pain
□ back pain □ strain □ whiplash □ poor posture
□ tendonitis □ bursitis □ limitation of movement
□ other *please explain*_____

BONE/JOINT
□ pain □ sprain □ dislocation □ disc degeneration
□ swelling □ fracture □ protrusion □ rheumatoid arthritis
□ prolapse □ bursitis □ osteoarthritis □ TMJ syndrome
□ other *please explain* _____

HEAD
□ headache □ migraine □ seizure □ brain injury
□ concussion □ earache □ vertigo □ ringing in the ears
□ other *please explain* _____

LUNGS/RESPIRATION
□ bronchitis □ asthma □ pneumonia □ chronic recurrent lung infections
□ emphysema □ allergies □ sinus infection □ shortness of breath
□ other *please explain* _____

HEART/CIRCULATION
□ heart attack □ stroke □ aneurysm □ high/low blood pressure
□ angina □ phlebitis □ fatigue □ varicose veins
□ poor healing □ bruise easily □ cold hands/feet
□ other *please explain* _____

OSTEOPATHY PATIENT INTAKE FORM CONTINUED

DIGESTION ☐ ulcers ☐ hiatal hernia ☐ diverticulitis ☐ irritable bowel syndrome
☐ acid reflux ☐ Crohn's disease
☐ other *please explain* _____

NERVOUS SYSTEM ☐ numbness ☐ tingling ☐ sciatica ☐ thoracic outlet syndrome
☐ other *please explain* _____

ORGAN DISEASE/ CONDITION ☐ heart ☐ lungs ☐ kidney ☐ liver
☐ stomach ☐ colon ☐ pancreas ☐ skin
☐ other *please explain* _____

OTHER DISEASE/ CONDITION ☐ Aids ☐ cerebral palsy ☐ epilepsy ☐ multiple sclerosis
☐ diabetes ☐ fibromyalgia ☐ chronic fatigue syndrome
☐ other *please explain* _____

SURGICAL OPERATIONS: _____

CURRENT MEDICATIONS: _____

MAJOR INJURY/ACCIDENT: _____

FOR WOMEN ONLY ☐ hysterectomy ☐ fibroid ☐ menopause ☐ dysmenorrhea
☐ bladder leak ☐ endometriosis ☐ miscarriage ☐ ectopic pregnancy
☐ other *please explain* _____
pregnancy due date _____ delivery/labour type _____
complications, if any _____
post-partum problems/pain ☐ no ☐ yes *please explain* _____
birth trauma ☐ no ☐ yes *please explain* _____

CHILDREN/ INFANTS ☐ dyslexia ☐ add/adhd ☐ colic ☐ learning disabilities
☐ irritability ☐ poor sleep ☐ slow development of fine/gross motor skills
☐ other *please explain* _____

EXERCISE ☐ rehabilitative ☐ competitive ☐ recreational
please explain the program _____

PATIENT'S CONSENT TO TREATMENT

I understand the information given on this form is strictly confidential, and will be released to other health care professionals or legal representatives only with my written consent.

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the therapist to stop or alter the treatment of clarity the reason for the particular technique being used.

_____ **Date** _____
Patient Name (Please Print)

_____
Patient Signature (Legal Guardian)