OSTEOPATHY INTAKE AND CONSENT FORM

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ (Bus.): _____ (Cell)_____

E-mail: _____

Date of Birth: _____

Occupation: _____ Primary Complaint: _____

Height: _____Weight: _____Blood Pressure: _____ Resting Pulse: _____

Please list presence of any internal pins, wires, artificial joints or special equipment: _____

Please list any allergies: _____

Name of Medical Doctor: _____ Phone: _____

How did you hear about us? ❒ Doctor ❒ Other Health Practitioner ❒ Website ❒ Signage
❒ Word of Mouth ❒ Other: _____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your main reasons for seeking treatment today (e.g. low back pain, headaches, etc.)?

_____

_____

_____

Prescription Drugs

List all prescription drugs that you are currently taking. Please indicate what the prescription is for.

_____

_____

Medical History

List any surgery's and when they occurred:

_____

_____

List any fractures and when they occurred:

_____

_____

List any major accidents and when they occurred (including car accidents) :

_____

_____

Have you ever been knocked unconscious or taken a significant blow to the head? Please circle:

Yes / No If Yes, please state when: _____

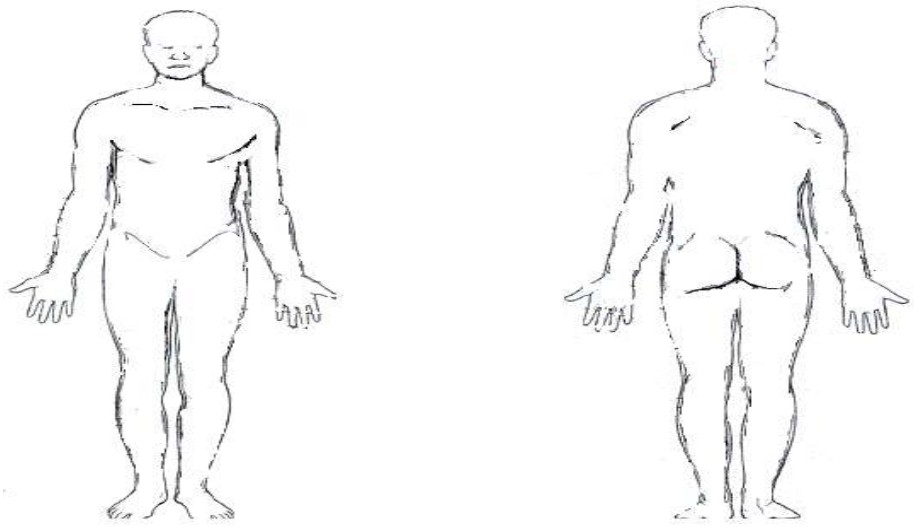
Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain

No pain at all _____ As bad as it could be

Pain Diagram

On the following diagrams, indicate all areas of:
Pain – xxxx Stiffness - //// Numbness - 0000
Other (Specify) - _____



Medical History

In the lists below, check all the areas you are currently experiencing, and place a 'P' in the box of areas you have experienced in the past.

General Symptoms

- ☐ Headaches
- ☐ Migraines
- ☐ Loss of Consciousness
- ☐ Blackouts
- ☐ Fever sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions / Seizures
- ☐ Loss of sleep
- ☐ Insomnia
- ☐ Chronic Fatigue
- ☐ Numbness and / or tingling
- ☐ Nervousness / Anxiety
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Weight loss / weight gain
- ☐ Hyperglycemia / Hypoglecemia
- ☐ Hepatitis A / B / C
- ☐ Edema
- ☐ HIV Positive &/OR AIDS
- ☐ Cancer
- ☐ Other: _____

Muscle and Joints

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Jaw pain
- ☐ Arthritis

Eyes / Ears / Nose / Throat

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing / buzzing in ears
- ☐ Frequent colds / infections
- ☐ Enlarged glands / thyroid
- ☐ Speech problems
- ☐ Difficulty swallowing

Respiratory

- ☐ Asthma
- ☐ Allergies
- ☐ Sinus problems
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pleurisy

Cardiovascular

- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Heart attack/myocardial infarction
- ☐ Anemia
- ☐ Stroke/cerebrovascular accident
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina
- ☐ Hemophilia / bleeding disorder
- ☐ Circulation problems
- ☐ Varicose veins
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Edema
- ☐ Poor circulation
- ☐ Other: _____

Gastrointestinal

- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Indigestion
- ☐ Ulcers
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gall bladder problems
- ☐ Irritable bowel syndrome
- ☐ Colitis
- ☐ Crohns disease
- ☐ Celiac disease
- ☐ Hiatus hernia
- ☐ Acid Reflux
- ☐ Other: _____

Female

- ☐ Painful menstruation / cramps
- ☐ Excessive flow
- ☐ Irregular cycle
- ☐ Endometriosis
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ STD
- ☐ Other: _____

Menopausal Y☐ N☐

Pregnant Y ☐ N☐

Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

Skin

- ☐ Rashes
- ☐ Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergy)
- ☐ Eczema
- ☐ Psoriasis

Genitourinary

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Urinary tract infection
- ☐ Incontinence
- ☐ Cystitis

Male

- ☐ Prostate problem
- ☐ Impotence
- ☐ Pain
- ☐ Infertility/low sperm count
- ☐ STD
- ☐ Hernia
- ☐ ED

Agreement

I agree that it is my choice to receive osteopathic treatment. I give permission for the therapist to work on all parts of my body (excluding private areas), including areas such as the head, neck and spine, tailbone, rib cage, front of the chest (sternum), abdomen, pelvis, arms and legs. I understand that the parts of the therapist's body may come into contact with mine at times during the treatment. I agree to communicate with my therapist at any time if I feel like my well-being is being compromised or I feel uncomfortable in anyway.

I understand that osteopaths do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that Miyako Kurihashi/Katharine Liberatore is not a medical doctor/physician, and that osteopathic treatment is not a substitute for medical examination or diagnosis. It is recommended that I see a primary health care provider for that service. I am also aware that there are no guarantees that these treatment(s) will completely relieve the symptoms for which I have consulted.

I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status. I understand that this osteopathic treatment is <u>not covered by OHIP</u>. The therapist is not responsible for any billing or dealings with private health insurance companies.

Signature: _____ Date: _____

Clinic Consent

Consent re: Personal Information and Treatment

We value the trust you have placed in us and are taking all appropriate measures to safeguard your personal information and confidence. We have established a privacy policy to ensure that your personal information and personal health information is protected. Our privacy policy is available at our reception and at *www.satoriwellness.com*. In accordance with our privacy policy, we request that you provide your consent as set out below.

I agree that Satori Health & Wellness can collect, use and disclose my personal information and personal health information provided by me in this client health inquiry history form to provide me with the services I request and for the other limited purposes set out in Satori Health & Wellness' privacy policy.

I hereby give my consent for treatment. I am also aware that Satori Health & Wellness will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered. I acknowledge that Satori Health & Wellness will not be responsible for any lost or stolen personal belongings.

I declare I will inform Satori Health & Wellness if there are any changes in my health history, upon my next visit.

I have been advised Satori Health & Wellness' 24hr cancellation policy, and I authorize a full service charge should this be enforced.

I wish to receive information about special events and updates from Satori Health & Wellness
☐ Yes ☐No

Signature

I attest that I have read and understood the above information and that the information provided in this form is true and accurate to the best of my knowledge.

Signature: _____ Date _____ Intake Practitioner: _____
Updated: _____