Céline NONZERVILLE
Registered Osteopathic Manual Practitioner

OSTEOPATHY INTAKE & CONSENT FORM

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

E-mail: _____

Male: ❒ Female: ❒ Date of Birth: _____

Occupation: _____ Employed By: _____

Marital Status: _____ Number of children: _____

Heigh: _____Weight : _____Blood pressure :_____

Emergency Contact: _____ Phone: _____ Relation: _____

Name of Medical Doctor: _____ Phone: _____

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

_____

Please list any allergies:_____

How did you hear about us? ❒ Website ❒ Friends/Family ❒ Doctor ❒ Word of mouth ❒

Other: _____

Would you like your therapist to send a progress report regarding your treatment to your;

❒ Family doctor ❒ Referring doctor/practitioner ❒ Other

If Yes, please provide contact information _____

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. The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information please feel free to ask.

Health Concerns

Primary reason for visit : _____

_____

Describe your general health : _____

Are you receiving treatment from other health care professionals ? Yes / No

If Yes, please explain : _____

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate present dose, how long you have been on each medication, and what the prescription is for.

_____

_____

Medical History

List any major surgery and when it happened?

_____

_____

_____

List any fractures and when they occurred?

_____

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

_____

Have you ever experienced a hard fall onto your back or buttocks? Indicate how and when.

_____

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

Please circle: Yes / No If Yes, please state when: _____

Are you pregnant now ; Yes / No

If Yes, please indicate the date of conception, and due date : _____

Family History

Please identify any problems that have occurred in your immediate family and indicate family members affected (diabetes, cancer, tumor, allergies, heart problems, high/low blood pressure, stroke, epilepsy, asthma, migraines, hepatitis, arthritis, other…)

_____

_____

Visual Pain Rating Scale

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

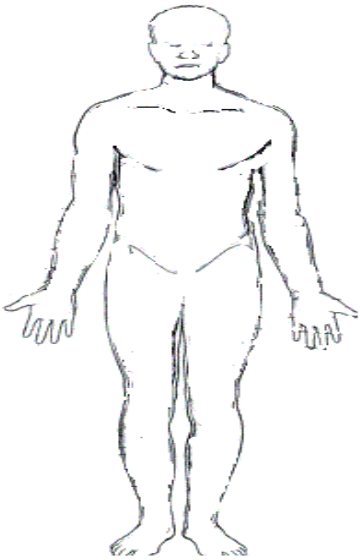
No pain at all _____ As bad as it could be

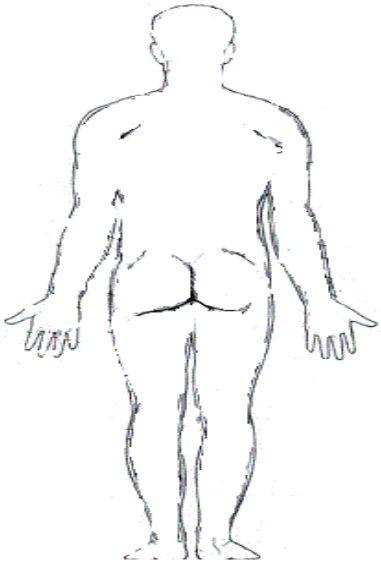
Pain Diagram

On the following diagrams, indicate all areas of:

Pain – xxxx Stiffness - //// Numbness - 0000

Other (Specify) - _____





Medical History

Please check "√" if you are experiencing the following symptoms or write 'P' beside the box if you have experienced these symptoms in the past.

General Symptoms

- ❑ Poor/Change in appetite
- ❑ Nervousness
- ❑ Weight gain/loss
- ❑ Headaches
- ❑ Migraines
- ❑ convulsions
- ❑ Cancer
- ❑ Diabetes
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Allergies
- ❑ Chills and fevers
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Cravings
- ❑ Strong thirst

Skin and Hair

- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Acne
- ❑ Loss of hair
- ❑ Thinning hair
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives or allergy reaction
- ❑ Boils
- ❑ Other skin problem(s)

Eyes Ears Nose Throat

- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Loss of taste/smell
- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Vertigo
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis
- ❑ Stroke/cardiovascular accident
- ❑ Pacemaker or similar device
- ❑ Artificial valve
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ anemia
- ❑ Fainting
- ❑ Chest pain
- ❑ Varicose veins
- ❑ Cold hands or feet
- ❑ Swelling of limbs

Respiratory

- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ Chest pain
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Coughing blood
- ❑ Throat phlegm
- ❑ Wheezing

Muscle, Bone & Joints

- ❑ Neck pain
- ❑ Back pain

- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Other pain
- ❑ Jaw pain
- ❑ Artificial joint

Gastrointestinal

- ❑ Indigestion
- ❑ Gas or burping
- ❑ Bad breath
- ❑ Constipation
- ❑ Diarrhea
- ❑ Incomplete bowel movements
- ❑ Abdominal pain or cramps
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Ulcers
- ❑ Acid reflux
- ❑ Blood in stool
- ❑ Irritable bowel syndrome
- ❑ Crohns disease
- ❑ Constant hunger
- ❑ Colon trouble
- ❑ Bloating
- ❑ Gall bladder trouble
- ❑ Intestinal worms
- ❑ Jaundice

Neurological

- ❑ Loss of balance
- ❑ Irritable
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Loss of sensation
- ❑ Emotional problems
- ❑ Other psychological problem

Infections

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV/AIDS

Genito-Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Blood in urine

Male

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Pain
- ❑ Infertility/low sperm count
- ❑ ED
- ❑ STD
- ❑ Hernia

Female

- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ Excessive flow
- ❑ Endometriosis
- ❑ Hot flashes
- ❑ Vaginal discharge
- ❑ Pregnant
- ❑ Infertility
- ❑ Painful vagina penetration
- ❑ Vaginal sores
- ❑ Sore breasts
- ❑ STD

Date of last Pap _____
Age of first menses __
Menopausal Y□ N□
Age of last menses ___
Pregnant Y □ N□
Do you practice birth control?
Y□ N□ Type _____
Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____
- episiotomy or c-section

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, the neck and spine, tailbone, rib cage, front of the chest (sternum), abdomen, pelvis, arms and legs. Many techniques will involve contact between your body and the practitioner's body. If intraoral work is required, disposable latex or vinyl gloves will be worn.

At times, the practitioner may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment or if you feel like your well being is being compromised, please tell us immediately. The techniques can be discontinued to be comfortable for you.
I understand that osteopaths do not diagnoses illness, disease or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that Céline NONZERVILLE 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 not covered by OHIP. The therapist is not responsible for any billing or dealings with private health assurance 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 Urban 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 Urban Wellness' privacy policy.

I hereby give my consent for treatment. I am also aware that Satori Urban 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 Urban Wellness will not be responsible for any lost or stolen personal belongings.
I declare I will inform Satori Urban Wellness if there are any changes in my health history, upon my next visit.

I have been advised Satori Urban 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 Urban Wellness
☐ Yes ☐ No

Please read and initial that you have read the following:

I understand that I, (please initial _____), will be charged **full price** for missed appointments, and **full price** for appointment modifications or cancelled appointments if I do not provide at least **24 hours advanced notice**.

Signature: _____ Date: _____

SIGNATURE

I attest that I have read and understood the abode information and that the information provided is true and accurate to the best of my knowledge.

I have been advised 24hr cancellation policy, and I authorize a full service charge should this be forced.

Signature: _____ Date: _____