OsteoMed Clinic

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647-830-4444
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Confidential Patient History

Patient Information

Last Name	First Name	Date of Birth (YYMMDD)
Address	City/Province	Postal Code
Home Phone	Cell Phone	Email
Employer	Occupation	How did you learn about us?
Insurance Company	Family Doctor Name	Family Doctor Phone

Overall, how is your general health?

_____

Current medications:_____
Condition it treats:_____

Fill in if applicable:

Surgery: _____ Date: _____
Nature: _____

Injury: _____ Date:
Nature: _____

Are you currently receiving treatment from another health care professional?

□ Yes □ No

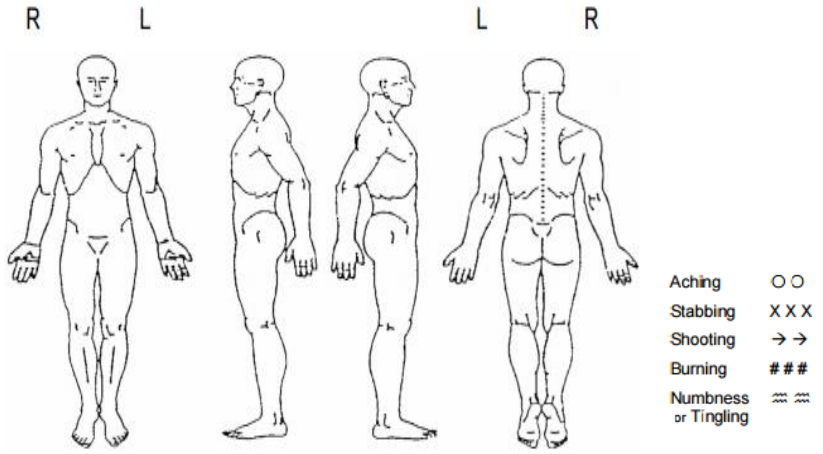
If yes, for what? _____

Do you have any internal pins, wires, artificial joints, or special equipment?

□ Yes □ No

If yes, what?_____
Where?_____

Please indicate on the diagram the nature of your symptoms, using the symbols:



Please indicate the conditions that apply to you:

Cardiovascular

□ High blood pressure
□ Low blood pressure
□ Chronic CHF
□ Heart Attack
□ Phlebitis/Varicose Veins
□ Stroke/CVA
□ Pacemaker/similar device
□ Heart Disease

Is there a family history of any of the above?
□ Yes □ No

Head/Neck

□ History of headaches
□ History of migraines
□ Vision problems
□ Vision loss
□ Ear problems
□ Hearing loss

Women

□ Pregnant, due: _____
□ Gynaecological conditions, which?_____

Respiratory

□ Chronic cough
□ Shortness of breath
□ Bronchitis
□ Asthma
□ Emphysema

Is there a family history of any of the above? □ Yes □ No

Other Conditions

□ Loss of sensation
□ Diabetes
□ Allergies/hypersensitivity to what? _____
Type of Reaction: _____
□ Epilepsy
□ Cancer, where? _____
□ Skin Conditions, which? _____
□ Arthritis

Is there a family history of arthritis? □ Yes □ No

Chief Complaint

What brings you to the clinic?

Informed Consent to Osteopathic Treatment

I the undersigned, give my full and voluntary consent to osteopathic treatment by a qualified osteopath practitioner. I acknowledge that I understand the nature of the treatment, the expected benefits of the treatment, and the material risks and side effects of the treatment proposed. I also understand that alternative treatment is available. I further comprehend the likely consequences of not having the treatment. I remain free to withdraw my consent at any time and the treatment shall cease at such time.

Informed Consent to Acupuncture Care

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electro acupuncture by the above-named practitioner. I understand and am informed that in the practice of acupuncture there are some risks to treatment, fainting, infection, shock, convulsions, possible perforation of internal organs and stuck or bent needles. I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Note: Female Patients: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there a possibility that I may be pregnant.

Informed Consent for Massage Therapy

In keeping with the Health Care Consent Act, it is my choice to receive massage therapy. I am aware that the time slot reserved for my massage includes time for interviewing, assessment, the actual massage treatment, any involving additional therapy, case follow-up, remedial exercises, and dressing and changing clothing as required. I am aware that it is not necessary to remove all articles of clothing for treatment and that I can decide to remove only the clothing which makes me feel comfortable. I agree to communicate with the massage therapist at any time that I feel my well-being is compromised. I am aware that I or the therapist may terminate the treatment at any point during the massage, at my or their discretion and without reasons. I am aware that I may experience possible side effects from the massage treatment, such as: temporary discomfort within the muscle (24-48 hours post treatment), bruising, headache, and dizziness.
I have read through and agreed to the above conditions. I also have had the chance to have all of my questions answered before agreeing to and receiving massage therapy treatment.

Consent for Personal Information and Understanding of Policies

I understand that all information recorded on the health history form is essential to providing me the most effective and safe treatment possible. **In signing this form I understand that everything discussed and/or recorded is strictly confidential and no information may be released or discussed with anyone without my consent.** I understand the fee schedule, and that payment is due when services are rendered along with any other statements pertaining to pay schedules. I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, the nature of and treatment in general, the treatment options and recommendations for my condition and the contents of this Consent. I intend this consent to apply to all my present and future treatment sessions at OsteoMed. I have read and understand the following policies:
Cancellation Policy: A 24-hour notice is required if you are unable to keep your appointment. Please be advised that if you fail to notify us in time, you may face the full price of your treatment.
Late Policy: Your late arrival will require that we end the session at the scheduled time, meaning your session will unfortunately be shorter today. We have reserved this time for you and only you and have other people scheduled after your time. No Show Policy: In the event that you fail to show up **without notification** for your scheduled appointment, please note that you are responsible to pay the full price of your session upon your next visit.

Client/Guardian Signature _____ Name (PRINT) _____

Witness _____ Date Signed _____