Osteopathy Intake Form and Consent

Name:_____

Date of Birth: _____**Age** _____

Address: _____

City: _____ **Postal Code:** _____

Phone Number Home: _____**Cell:** _____

E-mail Address: _____

Occupation: _____

Family Doctor:_____**Phone Number:**_____

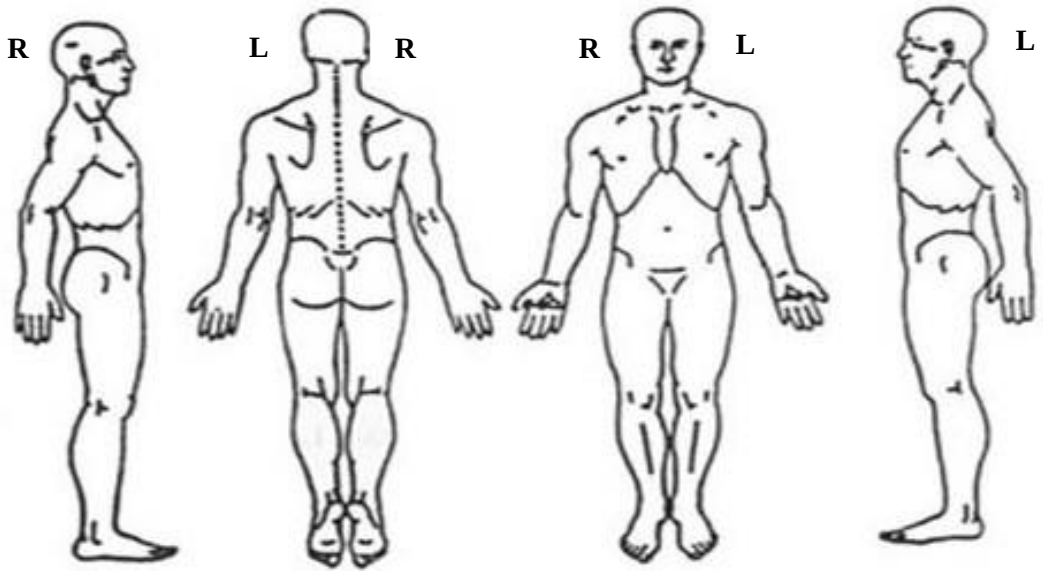
Referred By: _____

Primary Concern / Complaint:

_____

_____

Indicate Location of Pain, Discomfort, Numbness, Tingling and/or Tightness below:



Please List Any Previous Injuries and/or Accidents:

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____

Please List Any Previous Surgeries:

1. _____ **Date:** _____
2. _____ **Date:** _____

Please List Any Medications Taken in the Past 6 Months:

1. _____ **Purpose:** _____
2. _____ **Purpose:** _____
3. _____ **Purpose:** _____

Please Indicate Conditions You Are or Have Experienced

CARDIOVASCULAR
- ☐ High Blood pressure
- ☐ Low blood pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Bruise Easily
- ☐ Pacemaker

RESPIRATORY
- ☐ Chronic Cough
- ☐ Breathing Difficulty
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Do you smoke? Yes No

INFECTIONS
- ☐ Hepatitis A B C
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Herpes

SKIN
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Plantar Warts
- ☐ Athletes Foot

DIGESTIVE / URINARY
- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's / Colitis
- ☐ Ulcers
- ☐ Gallbladder
- ☐ Liver
- ☐ Kidney Infection
- ☐ Bladder Infection

HEAD & NECK
- ☐ Headache
- ☐ Migraine
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Vision Loss/Other Concerns

WOMEN
- ☐ Menstrual Concerns / Pain
- ☐ Endometriosis
- ☐ Menopausal Concerns
- ☐ Hysterectomy
- ☐ Pregnant
- ☐ Due Date_____
- ☐ Number of Children_____

MUSCLE / JOINT
- ☐ Muscle Strain
- ☐ Ligament Sprain
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis OA RA
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture
- ☐ Pins/Wires

OTHER CONDITIONS
- ☐ Diabetes
- ☐ Allergies _____
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Motor Vehicle Accident
- ☐

OTHER HEALTH CARE
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Medical Doctor
- ☐ Physiotherapy
- ☐ Naturopathy
- ☐ Osteopathy
- ☐ Others: _____

Back on Track
PHYSIOTHERAPY & HEALTH CENTRES
specializing in the treatment of active people

INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I understand that the Osteopathic Manual Therapist is providing osteopathic manual therapy services within their scope of practice.

I hereby consent to my Osteopathic Manual Therapist to treat me with Osteopathic manual therapy for the above-noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Manual Therapist.

I acknowledge that the Osteopathic Manual Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual therapy is not a substitute for a medical examination. It is recommended that I see my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Osteopathic Manual Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Therapist and have disclosed to the Osteopathic Manual Therapist all those medical conditions affecting me. It is my responsibility to keep the Osteopathic Manual Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Osteopathic Manual Therapist to release or obtain information pertaining to my conditions(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above-noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Osteopathic Manual Therapist from time to time, to deal with my physical conditions and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

CANCELLATION POLICY

Patients are required to provide 24-hour notice for any cancellations. That time has been reserved for you and we appreciate having adequate time to fill the spot. The clinic reserves the right to charge the full fee for a missed appointment or an appointment cancelled with less than 24-hour notice.

Thank you for respecting our time.

Initial:_____

DATE:_____ **Signature:**_____

Cancelation Policy

DATE: _____

Name: _____ DOB: _____
DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature

BACK ON TRACK PHYSIOTHERAPY

CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL INFORMATION

I, _____
(Print Full Name)

Of_____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

_____

_____

_____
(Print full names and institutions of affiliation)

In respect of

_____
(Print name of the client)

_____
(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

_____ _____

(Witness) **(Signature)**