Osteopathy Adult Intake Form

First Name:		Family Name:	
Birthdate: *(dd/mm/yyyy)*		Sex:	
Height		Weight	
Home Phone		Cell/ Work Phone:	
Emergency Contact:		Phone:	
E-Mail:			
Mailing Address:			
Civic Address			
Referring health practitioner:		Family doctor:	
Sports, Activities, Hobbies			

How did you hear about the clinic?

Current Health Condition:
Current complaint(s)

When did this condition begin? ___
How did this condition begin?

Have you had this problem before?

☐	yes	☐	no

If yes, have you had past treatment?

☐	yes	☐	no

Have you seen anyone else for this problem?

☐	yes	☐	no

Is it:

☐	job related	☐	fall or trauma
☐	car related	☐	repetitive stress

Date of accident: ___

***Characteristic* of pain:**

☐	sharp	☐	pins & needles	☐	constant
☐	dull	☐	burning	☐	intermittent
☐	aches	☐	numb	☐	other

What makes the pain *worse*?

☐	sitting	☐	bending	☐	desk work
☐	standing	☐	sleeping		

<u>Other:</u>

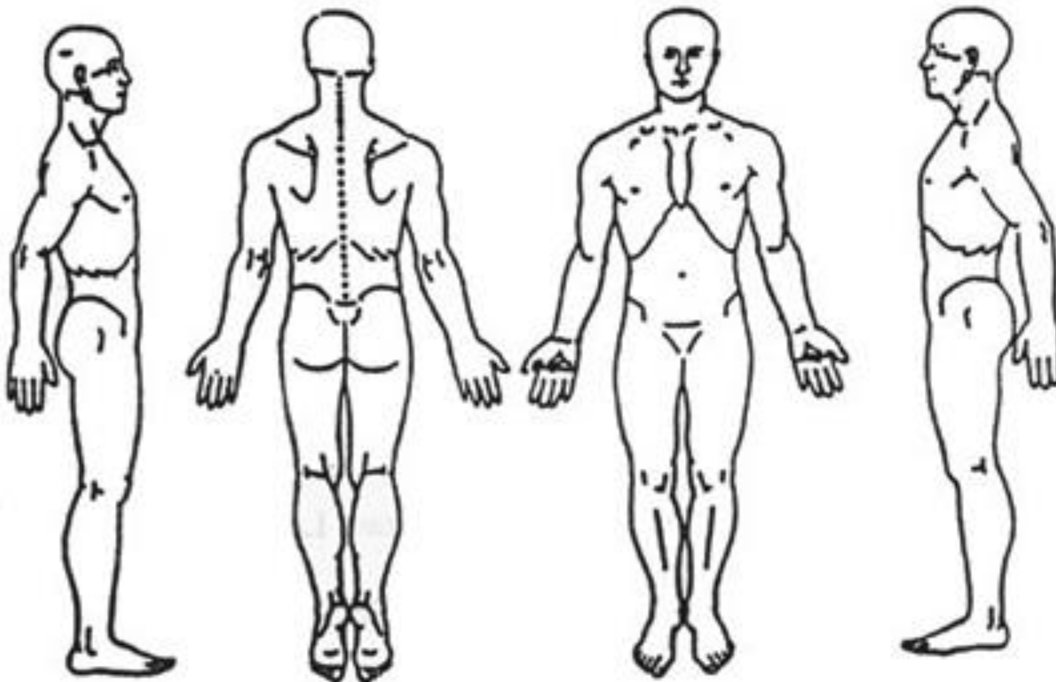
What Makes The Pain *Better*?

☐	bed rest	☐	activity	☐	getting better
☐	ice	☐	medication	☐	comes/goes
☐	heat	☐	other	☐	constant
☐	massage	☐	condition is	☐	worse

What are your treatment goals?

69 Cedar Street, P O Box 207, Windsor, NS, B0N2T0 1(902) 472-3510

Please mark an *X* on area of concern
Please mark *(-/-/-/-/)* on area(s) with surgery scars



<u>Past Health History</u>
List all surgeries /operations /hospitalisation *(within the last year).*

Scars?

☐ yes ☐ no

Location?

<u>Major illness (past/ present):</u>

Cancer

- ☐ yes ☐ no

Other:

- ☐ Yes ☐ no

List all broken bones, fractures, sprained/torn ligament:

List all motor vehicle accidents:

List all work injuries:

Do you wear orthotics or corrective footwear?

- ☐ yes ☐ no

Have you had X-rays or an MRI/CT?

- ☐ yes
- ☐ no

Latest or recent blood work:

Other medical tests?

Check any of the following you have had in the past:

- ☐ head and neck injury
- ☐ respiratory problems
- ☐ headaches
- ☐ asthma
- ☐ migraines
- ☐ bronchitis
- ☐ vision problems
- ☐ chronic cough
- ☐ ear problems
- ☐ shortness of breath
- ☐ digestive problems
- ☐ high blood pressure
- ☐ reflux
- ☐ low blood pressure
- ☐ constipation
- ☐ chronic congestive heart failure
- ☐ diarrhea
- ☐ heart attack
- ☐ Crohn 's Disease
- ☐ phlebitis or varicose veins
- ☐ colitis
- ☐ stroke
- ☐ irritable bowel syndrome
- ☐ pacemaker or similar device
- ☐ ulcers
- ☐ heart disease
- ☐ low appetite

Have you lost/ gained weight in last few months?

- ☐ yes
- ☐ no

How much? ___

Stress Level:

- ☐ high
- ☐ moderate
- ☐ low

Female Issues:

- ☐ menstruation problems
- ☐ menopausal problems
- ☐ breast pain /lumps
- ☐ sleeping problems
- ☐ pregnancy date
- ☐ sweating during night

Other

- ☐ food intolerances
- ☐ fibromyalgia
- ☐ allergies /hypersensitivity
- ☐ chronic fatigue
- ☐ diabetes (onset ___ type ___)
- ☐ scoliosis
- ☐ epilepsy
- ☐ polio/post polio
- ☐ arthritis
- ☐ osteoporosis
- ☐ hepatitis

Check The Medication(S) That You Take Regularly

- ☐ Insulin
- ☐ Antacids
- ☐ Heartburn Medication
- ☐ Laxatives
- ☐ Muscle Relaxers
- ☐ Arthritis Medication
- ☐ Blood Pressure Medication
- ☐ Birth Control Pills
- ☐ Pain Killers
- ☐ Vitamins
- ☐ Other: ___________

Missed appointment and cancellation policy:

We require at least 24 hours' notice for cancellation of appointments. As we have set aside the appointment time for you, should you cancel an appointment without adequate notice or if you do not show for your appointment, you will be billed directly for 50% of the amount. All cancellations and appointments should be made by phone. Please note that health insurance plans do not cover missed appointments and therefore receipts for such cannot be submitted to your insurance company for reimbursement.

Name: _________________________________

Signature: _________________________________

Date: _________________________________

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