Osteopathic Manual Therapy Health History Form

Name:______________________________ Email:____

Address:____

Street Apt City Province Postal Code

Birth Date: _____ /_____ /_____ Phone-Home:(______)______-______ Work/Cell:(______)______-________

Occupation (if retired, state former occupation) _____________________________ Referred By:________________

Hobbies and daily activities (even as a child) ____

____

Chief Complaints & when it started: ____

____

History of Complaint & when it started: ____

____

Current Medications including topical and herbal & dietary supplements and for what condition: ___________

____

Who else makes up your health care team (Family Doctor, Massage Therapist, Chiropractor, Physiotherapy, Chinese medicine, Reiki, etc. Please state frequency.) ____

Do you have difficulty with any of the following? (Please circle all that apply)

Headaches	Dizziness	Earaches	Ringing in Ears	Sinus Problems
Loss of Smell/Taste	Muscle & Joint Pain	Neck/Shoulder Pain	Back Pain (Upper/Mid/Low)	TMJ/Jaw Pain
Swollen/Stiff Joint	Rheumatoid Arthritis	Osteoarthritis	Pins/Needles in Extremities	Colds Hands/Feet
Sensitive Skin/Rashes	Varicose Veins	Deep Vein Thrombosis	Eczema/Psoriasis	Chest Pain
Heart Disease	Hi/Lo Blood Pressure	Heart Palpitations	Poor Circulation	Stroke
Phlebitis	Poor Digestion/Indigestion	IBS	Constipation	Diarrhea
Kidney/Bladder	Liver/Gallbladder	Chronic Cough	Shortness of Breath	Asthma
Bronchitis/Emphysema	Tuberculosis	Diabetes Type 1/Type 2	Thyroid Trouble	Cancer
HIV/AIDS	Hepatitis	Fatigue	Hormone Imbalance	Vision Problems/Loss
Vertigo	Hearing Loss	Sleep Disorder	Memory Loss	Anemia

Women

Menstruation- Painful/Heavy/Light/Normal/Irregular/Absent/Pregnant

Number of children: ____________

Menopause – Pre/Active/Post

Breast Tissue – Swollen/Painful/Cystic/Abnormal sensation/ Other

Allergies:____

Previous Medical History (dates) – Incl. Trauma/Car Accidents: _____________________________________

____

Surgical History (type and date):____

____

Family Medical History (cancer, diabetes, high/low Blood Pressure, Heart Disease, other): ________________

____

Social History (note frequency per week):

Tobacco ____ Coffee ____ Drugs ____ Alcohol ____ Other ____

Any Special considerations: □ Pacemaker □ Rods, Pins, Wires □ Artificial joints/limbs □ Medication Patch □ Other ____

______________________ ______________________ ____________________

Patient Name Printed Patient/Parent Signature Date (Month/Day/Year)

Osteopathic Manual Treatment Consent Form

All practitioners are bound by the regulations of the Health Care Consent Act set forth by the Ontario Ministry of Health. The Act serves to protect the right of informed choice and requires that an individual considering treatment must be fully informed and give valid consent to the proposed treatment.

- I, ______________________________________, acknowledge that Osteopathic Manual Therapy is not a substitute for medical diagnosis or examination. It is recommended that I see my primary care giver for that service.
- All the information recorded in the health history form is important to provide you with the most effective and safe treatment. In signing this form you understand that all information recorded is strictly confidential.
- Expected benefits and possible reactions to treatment have been explained to me and are understood (i.e. headaches, muscle aches and soreness, joint discomfort).
- I acknowledge that I have the right to withdraw my consent to treatment, treatment techniques, and areas to be treated at any time.
- I acknowledge that if I arrive late for my scheduled appointment, I will only receive the time remaining for the treatment.
- I understand that I must notify Roberto Valenzuela/Limitless Health Clinic of appointment cancellations 24 hours in advance of my scheduled treatment time.
- Patients under the age of 18 need to be accompanied by a parent or legal guardian for the initial treatment and must co-sign this document. If the patient is less than 16 years of age a parent or legal guardian must be present for all treatments.
- I have stated all relevant medical information that I am aware of and will update Roberto Valenzuela/Limitless Health Clinic of any changes to my health status (including medication, illness, injuries, etc).

__________________________ __________________________ _________/_________/_________

Patient Name Patient Signature Date

__________________________ __________________________ _________/_________/_________

Parent/Guardian's Signature Relation to Patient Date