Osteopathic Manual Therapy

Manual osteopathy is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of neuromusculoskeletal and joints complaints. Although manual osteopathy has an excellent safety record, no health treatment is completely free of potential adverse effects. The risks associated with manual osteopathy, however, are very small. Many patients feel immediate relief following manual osteopathy treatment, but some may experience mild soreness or aching, just as they do after some forms of exercise or massage. Current literature shows that minor discomfort or soreness following soft tissue therapy typically fades within 24 hours.

INFORMED CONSENT TO MANUAL OSTEOPATHIC CARE:

I hereby request and consent to the performance of osteopathic manual therapy performed by the osteopathic practitioner named.

I have had the opportunity to discuss with the osteopathic practitioner named any questions or concerns that I have regarding my condition and any forms of therapy to be administered. I understand that the results are not guaranteed.

I understand and am informed that, as in all health care, there are some very slight risks to treatment, including but not limited to, muscle aches and soreness following treatment. I do not expect the osteopathic practitioner to anticipate and explain all risks and complications, and I wish to rely on the osteopathic practitioner to exercise their judgment and I understand that all procedures are in my best interests.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's name: _____ Signature:_____

Date:_____ Witness to patient's signature:_____

New Patient Questionnaire

Date: .....

Patient Name: (Mr/Mrs/Miss/Ms) .....
(First Name) (Last Name)

Home Address: ..... Apt. No.: .....

City: ..... Postal Code: .....

Telephone: Home: ..... Work: ..... Mobile: .....

E-mail Address: .....

Patient Birth Date: .....
(Day/Month/Year)

How did you hear about this clinic? .....

Please help us grow by telling your friends, co-workers and family about us. Your referrals are greatly appreciated.

Family Doctor's Name ..... Address .....

Phone: ..... Fax: .....

Patient Signature ..... Date .....

If patient is under 16 years of age or if mentally challenged, a parent or guardian must sign below:

I, ... am the parent/guardian of the above named patient and give my full consent for examination and treatment of this patient.

Signature of parent/guardian .....

Please read and sign:

- I understand a 24 hours notice is required to cancel or reschedule all future appointments, or full charges will apply.

Health History and Entrance Form (please check all that apply to you)

General Symptoms

- ¤ Fainting / Dizziness
- ¤ Difficulty Sleeping /
- ¤ Fatigue
- ¤ Stress
- ¤ Headaches / Migraines
- ¤ Nervousness
- ¤ Numbness / Tingling; Where:_____ ¤ Paralysis

Skin

- ¤ Rashes
- ¤ Excessive Dryness
- ¤ Acne
- ¤ Psoriasis
- ¤ Eczema
- ¤ Skin Cancer
- ¤ Bruise Easily

Infections

- ¤ Hepatitis
- ¤ Tuberculosis
- ¤ HIV / AIDS
- ¤ Herpes
- ¤ Athlete's Foot
- ¤ Warts

Respiratory

- ¤ Chronic Cough
- ¤ Bronchitis
- ¤ Asthma
- ¤ Shortness of Breath
- ¤ Emphysema

Joint / Muscle Discomfort

- ¤ Jaw
- ¤ Neck
- ¤ Shoulders
- ¤ Arms
- ¤ Hands
- ¤ Upper Back
- ¤ Mid Back
- ¤ Low Back
- ¤ Hips
- ¤ Legs
- ¤ Knees
- ¤ Feet
- ¤ Bursitis
- ¤ Arthritis
- ¤ Family History of Arthritis

Do You Have / Had?

- ¤ Diabetes Onset
- ¤ Cancer; Where
- ¤ Epilepsy
- ¤ Aneurysm / Stroke
- ¤ Neuromuscular Conditions
- ¤ Hypo / Hyper Glycaemic
- ¤ Depression
- ¤ Multiple Sclerosis
- ¤ Thyroid Problems
- ¤ Fibromyalgia
- ¤ Osteoporosis
- ¤ Mental Illness
- ¤ Artificial Implants / Pins / Plates;

Where_____

Male / Female

- ¤ Prostate issues/swelling
- ¤ Pregnancy(ies)_____
- ¤ Menstrual Cramping ¤ Menstrual Irregularity ¤ Birth Control
- ¤ Vaginal Pain/Infections
- ¤ Breast Pain/Lumps
- ¤ Menopausal
- ¤ Urinary Incontinence ¤ Pain with intercourse

Cardiovascular

- ¤ High Blood Pressure ¤ Low Blood Pressure ¤ Heart Attack / Disease
- ¤ Congestive Heart Failure
- ¤ Stroke / Aneurysm
- ¤ Heart Murmur
- ¤ Pacemaker
- ¤ High Cholesterol
- ¤ Swelling of Ankles
- ¤ Cold Hands / Feet
- ¤ Poor Circulation
- ¤ Feet
- ¤ Varicose Veins / Phlebitis
- ¤ Family History of_____

Gastrointestinal

- ¤ Poor / Excessive Appetite
- ¤ Excessive Thirst
- ¤ Gas / Bloating
- ¤ Colitis
- ¤ Crohn's
- ¤ Constipation
- ¤ Diarrhea
- ¤ Nausea / Vomiting
- ¤ Ulcer
- ¤ Abdominal Cramps ¤ Gall Bladder Problems ¤ Liver Problems

EENT

- ¤ Vision Problems
- ¤ Dental Problems
- ¤ Sore Throat
- ¤ Ear Aches
- ¤ Hearing Difficulty
- ¤ Hearing Aid
- ¤ Stuffed Nose / Sinus
- ¤ Allergies / Hypersensitivity to

Type of Reaction_____

- ¤ Swollen Glands