CONFIDENTIAL OSTEOPATHIC INTAKE FORM

(please print clearly)

Name:_____Date_____

Date of birth :_____ (M/D/Y) Sex: M __ F__Non-Binary___
Address:_____
_____
_____

EmailAddress:_____
Empower your Health with monthly health tips by Nature's Touch: YES____ NO_____

Telephone number:Home:_____Work:_____

May we leave messages or email relating to your visits? YES_____ NO_____

Emergency contact: Name:_____ Phone number:_____ Relation:_____

**An accurate health history form is important to ensure a safe massage treatment. If your health status changes in the future, please let me know. All information gathered is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

How did you hear about our Clinic?_____

If referred, who were you referred by:_____

Other health care providers you are seeing:

1._____

2._____

What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Health History: Please check √ the symptoms that are present and X symptoms you have had in the past.

Head:
☐Headache
type_____
☐dizziness
☐earaches
☐sinus issues
where_____
☐neck pain
where_____
when_____
☐vision/hearing loss

Respiratory
☐chronic cough
☐shortness of breath
☐asthma
last attack_____
☐smoking
how many_____
☐catching of breath
☐breathing in
☐breathing out

Cardiovascular
☐blood pressure
high_____
controlled? Y N
low_____ fainting?
☐poor circulation
☐heart disease
what_____
when_____
familial_____
☐high/low cholesterol

Muscle and joints
☐arthritis type____
☐family history of arthritis
☐stiffness/swelling
☐discomfort/pain
☐decreased motion
which joint_____
☐osteoporosis?

Skin
☐sensitive skin
☐rashes/eruptions
☐acne
☐cold sores
☐bruise easily
☐varicose veins
☐phlebitis
☐eczema/psoriasis

Digestive
☐poor appetite
☐nausea
due too_____
☐constipation
☐consistent/occasional
☐difficult digestion
☐gas/belching
☐abdominal pain after eating

☐diabetes ☐cancer: type_____ ☐seizures ☐infectious diseases_____

Organs
☐liver
☐gall bladder
removal Y N
when_____
attacks Y N
☐kidneys
stones_____
☐bladder
weakness Y N
☐ovaries removal Y N
☐uterus removal Y N

Women
☐menstruation
☐painful
☐heavy
☐light
☐irregular how?
☐normal

☐pregnant
☐children#_____
☐menopause

Medical conditions: (all relevant)(pins,wires,etc.)Cancers.

_____

_____

_____

Allergies

_____

_____

_____

_____

_____

Current Medication (list all including Supplements and condition being treated.)

_____

_____

_____

_____

Surgeries

Date: Type: _____

_____

_____

_____

_____

_____

Accidents (MVA/Otherwise)

Date:_____Injury: (area of body)

_____

_____

_____

_____

_____

previous massage yes no
previous osteopathic tx yes no
previous cranial tx yes no
good sleeping patterns yes no
regular eating habits yes no
regular exercise yes no

Other health care (present√ or pastX)

☐Chiropractor
☐physiotherapy
☐acupuncture
☐psychotherapy
☐other

Signature of patient: _____

Date: _____

INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

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

I hereby consent to my Osteopathic Manual Practitioner to treat me with Osteopathic manual treatment 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 Practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual treatment is not a substitute for a medical examination. It is recommended that I attend 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 Practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Practitioner and have disclosed to the Osteopathic Manual Practitioner all of those medical conditions affecting me. It is my responsibility to keep the Osteopathic Manual Practitioner 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 Practitioner 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 treatment. 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 Practitioner 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.

_____ _____

Patient Printed Name Signature of Patient / Guardian

_____ _____

Osteopathic Manual Practitioner Date Signed

File Number:_____