Hawthorn
NATUROPATHY • ACUPUNCTURE • MASSAGE THERAPY
• OSTEOPATHY •

OSTEOPATHY INTAKE FORM

Please complete this Health History form as accurately as possible. These pages will help to ensure that you receive a safe and effective treatment. If at any time your health status changes, please let me know. All information is strictly confidential and will not be released to anyone without your written consent. If at any time you have any questions, please feel free to ask.

Name: _____ Sex: Female Male Other

Address: _____

City: _____ Postal Code: _____

Primary Phone: _____Email: _____

Age: _____ Date of birth: _____

Occupation: _____

(If retired, what did you do prior to retirement?)

Name of family physician: _____

Phone/address: _____

Date of last full physical exam: _____

Emergency contact(s): _____

Emergency contact number(s): _____

Relationship(s) with emergency contact(s): _____

Primary concern/concerns for seeking treatment:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any imaging done for any of the areas listed above or other? (ex: MRI, CT, X-ray, etc.)

_____

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Health History

Please circle beside which apply to you (or have previously applied to you in the past):

Head & Neck

Headaches/Type:

_____

Dizziness / Fainting / Vertigo

Earaches

Sinus problems

Neck pain

Memory Loss

Other (please specify):

_____

Muscle & Joint

Pain/stiffness

Swelling

Numbness

Osteoarthritis

Rheumatoid Arthritis

Tendonitis / Bursitis

Spondylolisthesis

Scoliosis

Other (please specify):

_____

Women

Menstruation:

Painful

Heavy / Light

Normal / Irregular / Absent

Other:

Pregnant (Y | N | MYB)

# of children:_____

Menopause

Hysterectomy

Other (please specify):

_____

Respiratory

Chronic cough

Shortness of breath

Asthma

Bronchitis

Emphysema (COPD)

Other (please specify):

_____

Skin

Sensitive skin

Rashes

Acne

Cold sores

Bruise easily

Varicose veins

Deep vein thrombosis

Eczema / psoriasis

Recent tattoos / piercings

Cardiovascular

High blood pressure

Low blood pressure

Poor circulation

Heart disease

Heart surgery

Pacemaker

Stroke

Phlebitis (vein inflammation)

Heart palpitations

Heart attack

Anemia

Other (please specify):

_____

Digestion

Poor/difficult digestion

IBS / Colitis

Crohn's Disease

Diarrhea / Constipation

Blood in stool

Painful Bowl Movements

Haemorrhoids

Liver / Gallbladder issues

Kidney / Bladder issues

Chronic Yeast Infections

Chronic UTI

Prostate dysfunction

Gallstones

Incontinence

Increased food sensitivities

Ulcers

Other (please specify):

_____

Other

Vision problems

Vertigo

Hearing loss

Ear problems (infections/tubes)

Hepatitis / Type:

_____

HIV / Herpes

Parasitic Infection

TB

Cancer

Anxiety / Depression

Bipolar Disorder

Sexual Dysfunction

Epilepsy

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General Stress Levels:

Please list a number between 1-10: _____

Diet:

How many cups of water do you consume in a day?

_____

How many cups of caffeine do you drink in a day? _____

How many meals do you eat in a day? _____

Eating disorder? _____

How many alcoholic drinks consumed in a week? _____

Do you smoke? How many packs/day _____

Exercise:

What physical activities do you engage in? Please list.

_____

_____

Day to Day:

Repetitive motions (what type) or any heavy lifting?

_____

Previous/Current Health Care and frequency of care/month:

Massage therapy: _____

Chiropractic: _____

Physiotherapy: _____

Acupuncture: _____

Osteopathy: _____

Psychotherapy: _____

Other: _____

_____

Allergies:

_____

Current prescription medications & any health products/vitamins *and reason for use:*

_____

_____

_____

Have you had any past injuries, accidents and/or surgeries?

1. Accident or surgery and reason:

_____

Date: _____ Medical Treatment Received: _____

2. Accident or surgery and reason:

_____

Date: _____ Medical Treatment Received: _____

3. Accident or surgery and reason:

_____

Date: _____ Medical Treatment Received: _____

Of special note: (pins, wires, mesh, prosthetics, walker, cane, etc.):

_____

Any additional notes for your therapist:

_____

CLIENT CONSENT & POLICIES FORM

Marina Rennie
Osteopathic Manual Therapist (M.OMSc)
Hawthorn Clinic

In signing this form you are fully aware and agree to all terms and conditions outlined in this document.

1. All information recorded on the health history form is essential to giving you the most effective and safe treatment possible. In becoming a client / patient of this therapist it is understood that everything discussed and/or recorded is strictly confidential and no information may be released or discussed with anyone without your consent.
2. As a new or returning patient / client it is necessary to have a full assessment performed. This is required so that a relevant, safe and effective treatment may be rendered. New health history forms must be revised after a long duration away from treatment, when seeing any new therapist for the first time, and / or if your health status changes. Assessment is part of the initial treatment and may take up to the first half hour of the initial appointment. You are agreeing to the fact that any changes to your health history have been fully disclosed to your therapist and that you are completely safe to treat.
3. By coming to this space you acknowledge that Osteopathic Manual Therapy is not a substitute for medical diagnosis or examination. It is recommended that you see your primary care giver for that service. Please be aware that **you will not be able to claim the treatment through WSIB or MVA claims either.**
4. I understand and agree that I am personally responsible for fees charged in connection with treatments provided. I agree to pay 50% of the appointment fee if an appointment is missed without 24 hours' notice. Missed appointments without notice may be issued a full charge of the time scheduled, except in the event of severe illness or family emergency.
5. Please arrive on-time to your scheduled appointment time. In the case of late arrivals it is fully understood that only the time remaining for your scheduled treatment will be allotted unless additional time is available.
6. In signing this document, you are giving full consent to assessment and treatment on this date and for any treatments that may follow. You are aware that you are taking on responsibility for any of the effects that may take place during or following the treatment today or in the future. In signing this document you also agree to all the terms and policies and have disclosed all information throughout the health history form that could possibly have an effect on your treatment outcome.
7. In signing this document I consent to text, calling and email communication with my therapist, including periodic emails informing me of seasonal featured treatments and natural health information.
8. Patients / Clients under the age of 18 must have a parent or legal guardian sign the consent form. If a client is under the age of 13, a parent or legal guardian must be present for all assessments and treatments that may follow.

Name_____ Date: _____

Signature_____

Signature of parent or guardian (if under 18) _____

Therapist Signature _____ Date: _____