collective HEALTHCLINIC

# OSTEOPATHIC HISTORY FORM AND CONSENT

Name

Address Postal code

DOB Phone (H) (C)

Email

Emergency Contact Emergency Phone No:

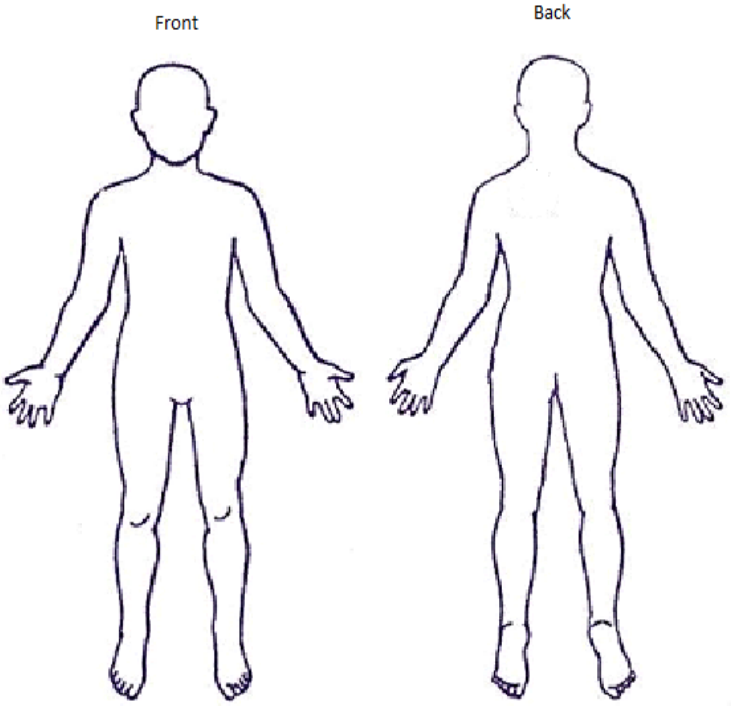
Occupation Employer

Family Doctor

How did you hear about this clinic?

Presenting Complaints primary/secondary:

Pain XXXXXX
XXXXXX
Achiness ////////
////////
Numbness oooooo
oooooo
pins and kneedles .'.'.'.'.'.'
.'.'.'.'.'.'




Have you received treatment from any of the following (circle)

Medical Doctor

Massage therapist

Chiropractor

Acupuncture

Osteopath

Other

Medications current/previous (please bring a list of current medications if you exceed the space provided)

Hospitalisations including: births, surgeries, fractures, trauma, illnesses, motor vehicle accidents (please include dates)

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Have you received any diagnostic testing: X-Ray, MRI, CT, Ultrasound, Bone density, blood work (date of test)

Please mark conditions that apply to you using a "C" for a Current Condition or a "P" for a Previous Condition.

| | | |
|---|---|---|
| (  ) Anxiety | (  ) Diarrhoea | (  ) Asthma |
| (  ) Anaphylaxis | (  ) Food sensitivity | (  ) Bronchitis |
| (  ) Chills | (  ) Gall bladder issues | (  ) Emphysema |
| (  ) Depression | (  ) Heart burn | (  ) Wheezing/coughing |
| (  ) Dizziness | (  ) Liver disease | (  ) Bed wetting |
| (  ) Fainting | (  ) Nausea | (  ) Painful urination |
| (  ) Fatigue | (  ) Ulcers | (  ) Urinary infection |
| (  ) Headaches | (  ) Ear aches | (  ) Kidney stones |
| (  ) Migraines | (  ) Tinnitus/ringing in ears | (  ) Prostate disease |
| (  ) Unexplained loss of weight | (  ) Deafness | (  ) Pregnant |
| (  ) Tremors | (  ) Sinus Infections | (  ) Menopausal |
| (  ) Loss of sleep | (  ) Hay Fever | (  ) Gynaecological condition |
| (  ) Arthritis | (  ) Sinusitis | (  ) Cramps with menstruation |
| (  ) Bursitis | (  ) Tonsillitis | (  ) Epilepsy |
| (  ) Hernia | (  ) Vision problems | (  ) Osteoporosis |
| (  ) Low back pain | (  ) Aneurysm | (  ) Fibromyalgia |
| (  ) Infectious skin condition | (  ) Heart failure | (  )Inability to control bladder |
| (  ) Allergies | (  ) Arthrosclerosis | (  ) Cancer |
| (  ) Crohn's disease | (  ) Heart attack | (  ) AIDS/HIV |
| (  ) Colitis | (  ) Pacemaker | (  ) Hepatitis |
| (  ) Constipation | (  ) Blood pressure high/low | Other |
| (  ) Diabetes | (  ) Heart disease | |

Consent:

I give my consent to allow Peter Foster, Osteopathic Manual Practitioner, to implement the physical assessment and treatment. I understand that the potential side effects may include (but are not limited to): muscle soreness, fatigue, exaggeration of symptoms. I understand that I may withdrawal my consent at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential in accordance with provincial laws and will not be released to others unless directed by myself or required by law.

I understand that there is a 24 hour cancelation policy. Should I miss my appointment, I am subject to pay a $40 cancellation fee.

Promptness is required for all appointments. In the event of lateness, the treatment may be cut short. Fees will be maintained per schedule.

Signature: