Precision Manual Osteopathy

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OSTEOPATHIC HEALTH INFORMATION

- Every detail you provide will help achieve your health goals and will remain confidential. Please bring this completed form to your first appointment.
- Please come to each appointment wearing or bring a change of clothes. For women, a tank top and shorts or yoga type pants (comfortable pants). For men; a t-shirt and shorts or comfortable pants. This is for diagnosing purposes, it is ideal to palpate the skin without layers of clothing impeding.
- During the Initial Appointment, an assessment will be performed. We will then discuss the findings with you and develop an appropriate treatment plan based on individual needs.

Name: _____ Date: _____

Date of Birth (dd/mm/yy): _____ Age: _____ Gender: _____

Address: _____

_____Postal Code: _____

Phone: _____ Email Address: _____

Occupation: _____

What is the best way for us to contact you? _____

May we leave a telephone message at home or work? _____

Would you like the receive our clinic email newsletter? _____

How did you hear about this health practice? _____

Please list all other healthcare practitioners you receive care from, including your dentist:

1._____ 2. _____ 3. _____

_____ _____ _____

Present Conditions: Why have you come, what's bothering you now?

_____

_____

_____

_____

Please list your primary health concerns, in order of importance:

1._____ Date of onset: _____

2._____ Date of onset: _____

3._____ Date of onset: _____

Do you have any other health concerns? _____

Please list any hospitalisations, surgeries (including dental), traumas (including emotional traumas) or major illnesses:

1._____ Date Started:_____ Date Resolved:_____

2._____ Date Started:_____ Date Resolved:_____

3._____ Date Started:_____ Date Resolved:_____

4._____ Date Started:_____ Date Resolved:_____

5._____ Date Started:_____ Date Resolved:_____

Please list any medication you taking, including antacids, pain medications, and laxatives:

1._____ Date Started:_____ Dose: _____

2._____ Date Started:_____ Dose: _____

3._____ Date Started:_____ Dose: _____

4._____ Date Started:_____ Dose: _____

Informed Consent

I understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side-effects. I am entitled to know the consequences of not accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that they have answered all of my questions to the best of their ability

I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

I accept full responsibility for any fees incurred during care and treatment. I understand that 24 hour notice is required to cancel an appointment or I will be responsible for a 50% late cancellation fee.

Client Signature : _____ Date: _____

Thank you for taking the time to fill out this questionnaire. It will greatly help in our study of present health concerns and our understanding of your health goals. Your responses will assist us in choosing the appropriate treatment that will hopefully bring about your return to optimal health.

Consent to the Collection, Use, and Disclosure of Personal Information

NOTE TO CLIENT: In accordance with the privacy act effective January 2004, we must ask for your informed consent. This means we want you to understand what we do with personal information. Your signature below allows us to obtain this information to open a confidential file for you. This is the only reason we collect your personal information.

I understand that you provide me with Manual Osteopathic goods and services, Precision Manual Osteopathy will collect some personal information about me (eg.: telephone, birthday, address, etc..).

We use and disclose your personal health information to:

- Treat and care for you
- Plan, administer and manage our internal operations
- Conduct quality improvement activities
- Teach
- Compile statistics
- Comply with legal and regulatory requirements

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance. We take steps to ensure that everyone who performs services for us protect your privacy and only use your personal health information for the purpose you have consented to.

I understand that only if I check off the following statement I will NOT receive the following:

- ❑ Newsletters and other informational emails from Precision Manual Osteopathy

I understand that, as explained in the policies and procedures for personal information, there are some rare exceptions to the commitments.

I agree to Precision Manual Osteopathy collecting, using and disclosing personal information about me as set out and in the Precision Manual Osteopathy privacy policy

Patient/Guardian Signature: _____ Date: _____

Patient's Printed Name : _____