Osteopathic Initial Treatment Form

Please fill in the following six pages to the best of your ability. If you have any questions, you are welcome to ask the reception staff or leave the space blank and we will discuss it in your appointment.

Personal Information

Name: _____ Date of Intake: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone number: _____ Email: _____

What is the best way to get ahold of you? _____

Occupation: _____ Length of Employment: _____

Date of Birth: _____ Age: _____

Family Physician

Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____ Alternative number: _____

St. George Wellness Centre

RECENT HEALTH

Primary Complaints:

Please explain:

_____

On a scale of 1 to 10, with 10 being the highest discomfort of my life, I would rate my discomfort a(n): _____

History of complaint: (please circle one from both lines):

Recent (<2weeks)	In the past 6 months	In the last 5 years	Longer than 5 years
Constant dull	Constant sharp	Comes and goes dull	Sudden and sharp

How would you describe your physical health? (5 – Very Healthy, 1-Not at all Healthy):

Overall health	5	4	3	2	1
Appetite	5	4	3	2	1
Exercise	5	4	3	2	1
Lifestyle	5	4	3	2	1
Work Life	5	4	3	2	1

Are you currently managing any physical conditions or diseases? **YES** **NO**

Please describe: _____

Any Pharmaceutical medication: _____

Any natural medicine/supplements: _____

Any dietary or physical limitations: _____

How would you describe your mental/emotional health? 5 4 3 2 1

FOR WOMEN:

# of pregnancies: _____ **# of children: _____**

OB/GYN or Midwife **Home of Hospital**

Please list birthing process and any complications: _____

_____

_____

HEALTH HISTORY

Please describe all that apply to you:

Injuries/accidents (type/year): _____

Bone anomalies: _____

Herniation/bulging disc: _____

Broken/Fractured Bones: _____

Pins/Wires/Plates: _____

Orthopedic Surgery: _____

Recurrent/Chronic infections: _____

Medications prescribed for more than 6 weeks: _____

Any changes in special senses (sight, hearing, etc): _____

Allergies/Sensitivities: _____

Cancer (type, treatment): _____

Heart condition: _____

Conditions/diseases (Please circle all that apply to you):

Anemia	Bleeding disorders	Immune deficiency	Thrombosis	Sickle cell
Tinnitus	Vertigo	Diabetes	Hyper/Hypothyroidism	
Glaucoma	Cataracts	Endometriosis	Ovarian cysts	Uterine fibroids
Amenorrhea	Ulcers	Reflux	Pancreatitis	HIV/AIDS
Crohn's	IBS	Kidney Stones	Hep A B C	Gallstones
ED	Infertility	Rheumatoid	Lupus	Gout
Stroke	Aneurysm	Parkinson's	MS	Headaches
Migraines	Epilepsy	Alzheimer's	Neuropathy	Spina bifida
Asthma	COPD	Cystic fibrosis	P. Embolus	P. Hypertension
P. Fibrosis	Pleural Effusion	Collapsed lung	TB	Eczema
Psoriasis	Depression	Anxiety	Bipolar	Other

Please use this space to list any conditions or concerns not mentioned on the last page:

_____
_____
_____
_____

Please list any conditions/diseases relevant in your family history, and the relationship:

_____
_____
_____
_____

Please circle all that apply to you:

Coffee **Alcohol** **Cigaretts/Cigars** **Recreational Drugs**

How often? _____

TREATMENT HISTORY

Are you currently seeing other practitioners for your condition? YES NO SOMETIMES

Type of treatment: Chiropractic Physiotherapy Massage Naturopath Acupuncture

Other: _____

Frequency of treatment per practitioner:

_____
_____
_____

Have you seen other Practitioners in the past for this condition? YES NO

Type of treatment: Chiropractic Physiotherapy Massage Naturopath Acupuncture

Other: _____

Frequency of treatment per practitioner:

_____
_____
_____

Are you seeing/have you seen any other Practitioners for other conditions?

Chiropractor Condition: _____

Physiotherapist Condition: _____

RMT Condition: _____

Naturopath Condition: _____

Acupuncture Condition: _____

Counselling Condition: _____

St. George Wellness Centre

Informed Consent

By signing this form I acknowledge the following:

- *I have given Sarah Sparks, Osteopathic Manipulative Practitioner my consent for treatment through hands-on Osteopathic techniques. I understand that I may withdraw my consent at any time throughout the treatment by informing Marie Baker immediately. I will inform Marie Baker immediately if I disagree with any approaches used during the treatment and I am therefore giving constant verbal consent.*

- *I have given Ashley Jasinski, Osteopathic Manipulative Practitioner my consent for treatment through hands-on Osteopathic techniques. I understand that I may withdraw my consent at any time throughout the treatment by informing Ashley Jasinski immediately. I will inform Ashley Jasinski immediately if I disagree with any approaches used during the treatment and I am therefore giving constant verbal consent.*

Patient name (please print): _____

Patient Signature:_____ Date: _____

Parent/Guardian Signature (if applicable) _____ Date: _____