St. George
Wellness Centre

Osteopathic Initial Treatment Form-CHILD

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: _____

Date of Birth: _____ Age: _____

Family Physician

Name: _____

City: _____ Province: _____ Postal Code: _____

Phone number: _____

Emergency Contact

Name: _____

Relationship: _____

Phone number: _____ Alternative number: _____

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RECENT HEALTH

Primary Complaint:

Please explain:

_____

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

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

Recent (< 2 weeks) In the last 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

Are you currently managing any mental/emotional conditions or diseases? Yes No
Please describe:_____

Any pharmaceutical medication:_____

Any natural medicine/supplements:_____

Any dietary or physical limitations:_____

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HEALTH HISTORY

Please describe all that apply to you:

Injuries/accidents (type/year):_____

Bone anomalies:_____

Broken/Fractured Bones:_____

Recurrent/chronic infections: _____

Medications prescribed for more than 6 weeks: _____

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

Allergies/Sensitivities: _____

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

anemia bleeding disorders immune deficiency ear infections pneumonia

vertigo diabetes headaches migraines epilepsy constipation strep

asthma eczema psoriasis depression anxiety teething diarrhea

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:

_____

_____

_____

How was your own birthing process? C-Section Vaginal Birth V-birth with complications

Are you willing to make changes to your lifestyle for your wellbeing? Yes No Depends

What are your expectations from treatment: Cure Relief Decrease in symptoms

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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:_____

Acupuncturist Condition:_____

Counselling Condition:_____

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Informed Consent

By signing this form I acknowledge the following:

- *I have given Marie Baker, 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: _____