OSTEOPATHIC MANUAL THERAPY:

Manual Osteopathy is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of neuromusculoskeletal and joints complaints. Although manual osteopathy has an excellent safety record, no health treatment is completely free of potential adverse effects. The risks associated with manual osteopathy, however, are very small. Many patients feel immediate relief following manual osteopathy treatment, but some may experience mild soreness or aching, just as they do after some form of exercise or massage. Current literature shows that minor discomfort or soreness following soft tissue therapy typically fades within 24 hours.

INFORMED CONSENT TO MANUAL OSTEOPATHIC CARE:

I hereby request and consent to the performance of osteopathic manual therapy performed by the Emily Thompson, DOMP.

I have had the opportunity to discuss with the osteopathic practitioner named any questions or concerns that I have regarding my condition and any forms of therapy to be administered. I understand that the results are not guaranteed.

I understand and am informed that, as in all health care, there are some very slight risks to treatment, including but not limited to, muscle aches and soreness following treatment. I do not expect the manual osteopathic practitioner to anticipate and explain all risks and complications, and I wish to rely on the manual osteopathic practitioner to exercise their judgment and I understand that all procedures are in my best interests.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's name: _____ Signature:_____

Date:_____

PATIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ Province: _____

Email Address: _____ Occupation: _____

(Please answer all area; filling out this form completely will help ensure the best possible care.)

What is the major complaint or condition you are seeking help for? _____

_____

What did this begin? _____

What brought it on? _____

_____

What have you done to get relief?

What positions/activities aggravate the condition? _____

_____

What does this condition prevent you from doing? _____

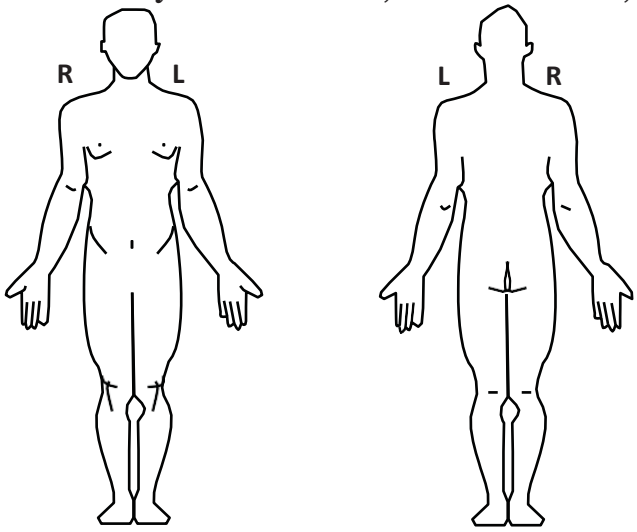
_____

Is this condition: [ ] worsening [ ] improving [ ] unchanged

Have you seen a physician for this? **Yes / No**

Are you now under medical / therapeutic treatment? **Yes / No**

Please mark your conditions, area of concern, pain



Please list all medications and nutritional supplements you are taking:

_____

_____

_____

_____

Please list all surgeries in your lifetime:

_____

_____

_____

_____

Please list therapies you currently receive:

_____

_____

_____

_____

_____

Please list any additional comments regarding your health and well-being:

_____

_____

_____

_____

Emergency Contact Name: _____

Phone Number:_____ Relationship:_____