BODY ESSENCE THERAPY CLINIC

MANUAL OSTEOPATHIC

Personal Information

Name ______________________ Phone (day)______________(evening)____________

Address ____________________City_______________PostalCode_______________

Date of birth_________________Occupation________________Employer____________

Email _____________________ Primary Physician ______________________________

Emergency Contact __________________Relationship _____________ Phone__________

How did you hear about us? ____

What are your goals for today's treatment? ______________________________________

Health History:

Have you had a manual osteopathic treatment before? Yes _____ No _____

If yes, for what? ____

Are currently being treated by a Chiropractor or Physical Therapist? Yes _____ No ______

If yes, for what? how long have been? ____

Are you taking any medications? Yes _____ No _____

If yes, please list name and use: ____

Are you currently pregnant? Yes _____ No _____ Due date ________________________

If yes, how far along? ______________ any high risk factors? _______________________

Do you suffer from chronic pain? Yes ______ No _____

If yes, please explain ______________________ What makes it better? ________________

Any injuries within past 72 hours? Yes _____ No _____ Explain ________________________

Past Surgeries ________________________ Any implants ____________________________

Medication/THC/ACB/supplements ____

Allergies ____

Please indicate Current conditions or any chronic conditions:

Respiratory:

Skin:

____ Chronic cough

____ Shortness of breath

____ Bronchitis/Asthmas

____ Sinus infections

____ Emphysema

____ Smoke/Vape

Cardiovascular:

____ Cold hand/feet

____ Heart disease

____ Varicose veins

____ Poor healing of wounds

____ Stroke/CVA

____ Swelling in hands/feet

Infections:

____ Hepatitis

____ Tuberculosis

____ HIV

Head and Neck:

____ Tension/Migraine headaches

____ Tinnitus (ringing in ears)

Soft tissue/Joint/Nerve:

____ Fibromyalgia

____ Arthritis ____ RA ____ OA

____ Herniated Disc (s) Level ____

____ Osteoporosis

____ Fracture (where: __________)

____ Head trauma/concussion

____ Whiplash/car accident

____ Bruise easily

____ Rash/open sore/warts

____ Sensitivities/allergies: ___________

____ Contagious skin disease

Digestive:

____ Constipation

____ Nausea/vomiting

____ Ulcers/blood in stool

____ Liver/kidneys problems

____ Quick weight lose/gain

____ Appetite changes

____ Ulcerated colitis/Crohn's

____ Carpel tunnel syndrome

Women:

____ Painful menstruation

____ Hysterectomy

____ Birth control ____ C-section

Other conditions:

____ Loss of sensation

____ Diabetes (onset/type: _________)

____ Epilepsy

____ Insomnia

____ Depression/Anxiety

____ Multiple Sclerosis

____ Cancer (onset/type: ___________)

____ Other: ________________________

____ Post-traumatic stress disorder, explain

____

____ Neck pain/stiffness/injury

____ Arm pain/weakness/tingling

____ Knee or foot pain/injury

____ Tendonitis/Tenosynovitis

____ Bursitis or dislocations

____ Sleep quality

____ Well-balanced diet

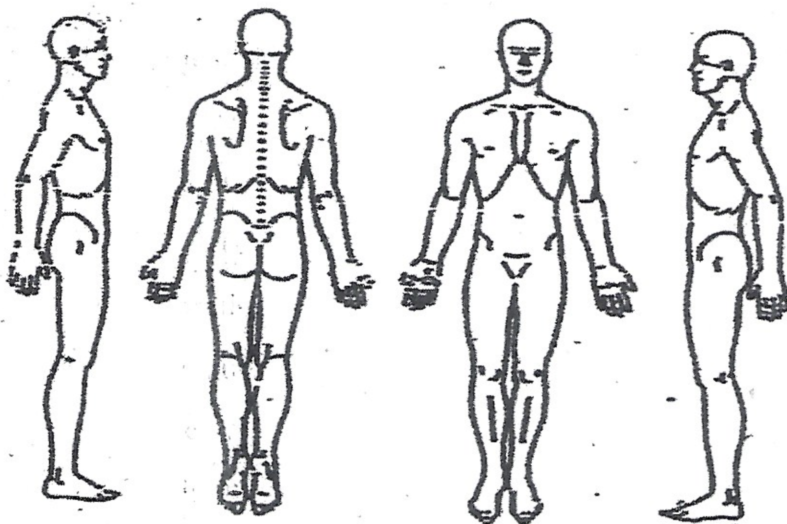
____ Energy level

____ Happiness/Contentment

Addition information: ____

Describe your current pain ____

Intensity of pain 0-10 _____ What aggravates it: _______________ What relieves it: _________



Signature: ________________________________ Date: ________________________________

Therapist: ________________________________ Date: ________________________________

INFORMED CONSENT

I understand that the Manual Osteopathic Therapist is providing Manual Osteopathic Therapy services within their scope of practice. I hereby consent for my Therapist to treat me with Manual Osteopathic Therapy for the above noted purposes including such assessments, examination, and techniques, which may be recommended, by my therapist.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the Manual Osteopathic Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Cancellation requires 24 hour prior to the appointment, otherwise, there will be $75 fee charged.

I authorize and consent my therapist to use the information pertaining to my condition(s), and /or treatment plan for a case study. Yes______ No______

Client Name ______________________________

Signature of Client ______________________________ Date______________________________