

OSTEOPATHIC MANUAL THERAPY INFORMED CONSENT

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Biodynamics Toronto. This clinic utilizes the principles and practices of Osteopathy, a natural medicine which aims to restore the function in the body by treating the causes of pain and imbalance. To achieve this goal the Osteopathic Manual Practitioner relies on the quality and finesse of their palpation and works with the position, mobility and quality of the tissues.

The treatment and advice provided to you by the Osteopathic Manual Practitioner is not being provided in place of, or to the exclusion of, any other treatment or advice that you may now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner. It is your responsibility to inform your practitioner of any pre-existing medical conditions, injuries or disease of which you are currently aware of. Your proposed treatment is based on Osteopathic manual practice and may contain some or all the following: gentle mobilization of the joints, muscles, connective tissue, fluids, viscera and nerve pathways. It combines different manual techniques based on the principles of Osteopathic diagnosis and treatment, including advice on posture and exercise within the Osteopathic scope. It is your right and responsibility to inform the practitioner of your condition during your treatment. The Osteopathic Manual Practitioner reserves the right to discontinue services where it is apparent that your expectations and the type of services provided are not compatible.

I should expect to be evaluated and treated in my undergarments or shorts and sports bra. I agree to be treated in my undergarments or in loose shorts and sports bra.

Privacy of your personal information is an important part of providing you with quality Osteopathic care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards set out by the Ontario Association of Osteopathic Manual Practitioners.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, for insurance or health reasons I understand that I may look at my medical records at any time and can request a copy of my file with a fee of \$0.10 per page with at least 72 hours' notice. Additional charges may apply if your practitioner is requested to write letters for insurance or medical practitioner purposes.

I understand that I need to give 24 hours' notice for any cancellation. If I give less than 24 hours' notice then I agree to pay the sessions full fee. Exceptions may apply at the practitioner's discretion. If you are late for an appointment please be advised that the appointment will not continue past the previously scheduled end time.

I understand that the results are not guaranteed. I do not expect the Osteopathic Manual Practitioners to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Osteopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient or Legal Guardian Name _____

Signature of Patient or Guardian _____ **Date:** _____

OSTEOPATHIC MANUAL THERAPY PATIENT INTAKE FORM

This is a confidential record of your personal information and your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Personal information

Name _____

Phone _____ E-mail _____

Address _____

City _____ Province _____ Postal Code _____

Date of Birth _____ Male Female

Occupation _____ Employed By _____

Marital Status _____ Number of children _____

Emergency contact _____

Phone _____ Relation _____

Medical doctor _____ Phone _____

How did you hear about us? Website Social media Friends Family Newspaper
 Other _____

PRESCRIPTION DRUGS

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.

SURGERY

List any major surgery you have had.

#1 year _____ nature _____

#2 year _____ nature _____

#3 year _____ nature _____

Do you have any internal pins or artificial device? Y N Nature _____

MEDICAL HISTORY

In the lists below, check all major illnesses that you have experienced.

Childhood disease

- Measles
- German measles
- Chicken pox
- Mononucleosis
- Mumps
- Whooping cough
- Scarlet fever
- Polio
- Reye's syndrome

Infectious disease

- Worms/Parasites
- Cholera
- Malaria
- Typhoid
- Tuberculosis
- Syphilis
- HIV

Ears Nose Throat system

- Environmental allergies
- Hay fever
- Ear infections (repetitive)
- Tonsillitis
- Strep throat
- Chronic sinusitis
- Eye Problems

Respiratory system

- Bronchitis
- Pneumonia
- Pleurisy
- Asthma
- Emphysema

Cardiovascular system

- Heart problems
- Heart attack
- Angina
- Congestive heart failure
- Stroke/CVA
- Aorta aneurysm
- Varicose veins
- Phlebitis/Thrombosis
- Raynaud's disease
- Low blood pressure
- High blood pressure
- Pacemaker/Artificial valve

Gastrointestinal tract

- Digestive allergies

- Food poisoning
- Esophageal varicose
- Hiatal hernia
- Stomach/Duodenum ulcers
- Crohn's Disease
- Irritable bowel syndrome
- Candida yeast syndrome
- Appendicitis
- Pancreatic disease
- Liver disease
- Jaundice
- Wilson's disease
- Hepatitis
- Gall bladder disease
- Spleen disease
- Colitis
- Diverticulitis
- Hemorrhoids
- Colorectal disease

Genito-urinary system

- Urinary tract infections
- Bladder problems
- Kidney stones
- Kidney infections

Female

- Uterine fibroids
- Endometriosis
- Ovarian cysts
- Vaginitis (recurrent)
- Human Papillomavirus
- Fibrocystic breast disease
- Infertility

Male

- Prostate problem
- Impotence
- Scrotal hernia
- Infertility/Low sperm count

Pelvic inflammatory diseases

- Chlamydia/Gonorrhea
- Genital warts
- Genital herpes
- Herpes (cold sores)

Endocrine disease

- Diabetes
- Hypothyroid
- Hyperthyroid
- Cushing's Disease

- Addison's Disease

Muskuloskeletal system

- Rheumatoid arthritis
- Osteoarthritis
- Rheumatism/Arthritis
- Fibromyalgia
- Osteoporosis/Osteopenia
- Myasthenia gravis
- Rickets syndrome
- Herniated disc
- Bursitis

Neuro

- Concussion
- Epilepsy
- Meningitis/Encephalitis
- Multiple Sclerosis
- Sciatica
- Thoracic outlet syndrome

Metabolic diseases

- Hypoglycemia
- Anemia
- Platelet disorder
- Gout
- Lupus
- Malnutrition
- Cancer, specify type:

Skin

- Acne
- Boils
- Impetigo
- Eczema
- Shingles
- Psoriasis
- Warts
- Hives
- Ulcers
- Skin cancer

Psychological

- Schizophrenia
- Bipolar disease
- Clinical depression
- Suicidal tendencies
- Eating disorder
- Emotional problems
- Other psychological problem

Please check the box if you are currently experiencing the following symptoms or write "P" if you have experienced them in the past.

General

- Poor/Change in appetite
- Nervousness
- Weight gain
- Weight loss
- Poor sleep
- Chronic fatigue
- Chills and fevers
- Night sweats
- Sweat easily
- Cravings
- Strong thirst

Ears Nose Throat

- Migraine/Headaches
- Facial pain/tics
- Ear aches
- Ringing in ears
- Vertigo
- Nasal obstruction
- Post nasal drip
- Nosebleeds
- Loss of taste/smell
- Sinus infection
- Enlarged glands
- Enlarged thyroid
- Sore throat

Eyes

- Eye pain
- Eye strain
- Blurry vision
- Impaired vision

Dental

- Jaw pain or clicks
- Mercury fillings
- Sores in mouth
- Grinding/Clenching teeth
- Extractions
- Orthodontia

Respiratory

- Difficulty breathing
- Chronic cough
- Shortness of breath
- Coughing blood
- Throat phlegm
- Wheezing

Cardiovascular

- Palpitation
- Irregular heartbeat
- Fainting
- Chest pain
- Cold hands or feet
- Swelling of limbs
- Poor circulation

Gastrointestinal

- Bad breath
- Gas or burping
- Indigestion
- Constipation
- Diarrhea
- Incomplete bowel movements
- Abdominal pain or cramps
- Nausea
- Vomiting
- Chronic laxative use
- Rectal pain
- Blood in stool
- Constant hunger
- Colon trouble
- Bloating

Musculoskeletal system

- Neck pain
- Back pain
- Muscle pain
- Other pain
- Orthotics

Skin and Hair

- Rash
- Itching
- Loss of hair
- Thinning hair
- Dandruff
- Recent moles
- Dryness
- Allergic reaction
- Keloids
- Other skin problem(s)

Female

- Premenstrual syndrome

- Irregular periods
- Heavy flow
- Light flow
- Clots
- Pain/Cramps
- Sore breasts
- Vaginal discharge
- Lower back pain
- Menopause

Birth control Type: _____

Date of last Pap _____

Age of first menses _____

Pregnancy

- Currently pregnant
- Extra-uterine pregnancy
- Abortion
- Miscarriage
- Epidural
- Episiotomy
- C-section
- Pelvic floor rehabilitation
- Uterine prolapse
- Gestational diabetes
- Pre-eclampsia
- Other pregnancy related illness

Urinary system

- Frequent urination
- Urgency to urinate
- Pain on urination
- Wake up at night to urinate
- Incontinence
- Blood in urine

Neuro

- Numbness
- Muscle weakness
- Loss of balance
- Irritable
- Poor memory
- Anxiety
- Dizziness
- Lack of coordination
- Seizure
- Loss of sensation

HEALTH CONCERNS

- **What are your main health concerns in order of importance to you?**

- **Visual Pain Rating Scale**

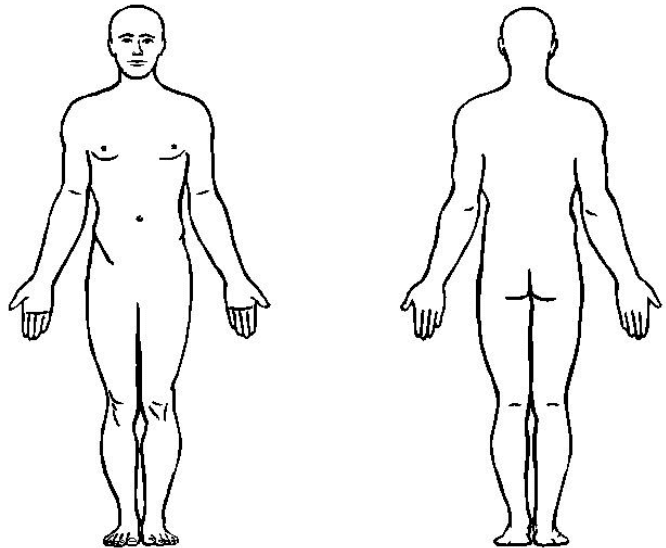
Make a mark along the line which you think represents your current level of pain.

No pain at all _____ As bad as it could be

- **Pain Diagram**

On the following diagrams, indicate all areas of:

- Pain : XXXX
- Stiffness : ///
- Numbness : 0000
- Other (specify) :



SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____

Date: _____

Thank you for taking the time to fill out this questionnaire.

It will help greatly in our study of your present health concerns and in our understanding of your health goals.

Your responses will assist us in choosing the appropriate treatment that will bring about your return to optimal health.