Tri-City Natural Health Care Centre Osteopathic Initial Intake Form

Edward Schroeder, DOMP, DScO

CONFIDENTIAL HEALTH HISTORY

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ POSTAL CODE: _____
PHONE (H): _____ (W): _____ (C): _____
EMAIL ADDRESS: _____ May we contact you via email? Yes / No
OCCUPATION: _____ BIRTH DATE: M_____ D_____YR_____ AGE:_____
PRIMARY CARE PHYSICIAN: _____ CITY OR PHONE #:_____
EMERGENCY CONTACT: _____ PHONE #: _____
HOW DID YOU HEAR ABOUT OUR CLINIC? _____
MY CHIEF COMPLAINT TODAY IS: _____
MY CHRONIC COMPLAINT IS: _____

MEDICAL HISTORY - Please indicate any conditions that apply to you (past or present).

Cardiovascular Conditions
□ High Blood Pressure
□ Low Blood Pressure
□ Chronic Congestive Heart Failure
□ Heart Disease
□ Phlebitis/Blood Clots
□ History of Heart Attack
□ History of Stroke
□ Pacemaker (or similar device)
□ Irregular Heart Beat/Arrhythmia
□ High Cholesterol
Other _____
Family History Yes □ No □

Respiratory Conditions
□ Asthma
□ Emphysema/COPD
□ Shortness of Breath
□ Bronchitis
□ Chronic Cough
Other _____
Family History Yes □ No □

Infectious Conditions
□ Hepatitis: type_____
□ HIV/AIDS
□ Tuberculosis
□ Infectious skin conditions
Other _____

Digestive Conditions
□ Gastroesophageal Reflux/GERD
□ Peptic/Duodenal Ulcer
□ Gallstones/Gall Bladder Disease
□ Irritable Bowel Syndrome
□ Constipation
□ Diverticulitis
□ Crohn's/Colitis
□ Haemorrhoids
Other _____

Genitourinary Conditions
□ Incontinence
□ Urinary Tract Infection
□ Kidney Disease
□ Prostatitis
□ Bedwetting
□ STD/STI
Other _____

Women Only:
□ PMS/Cramps/Menstrual Issues
□ PCOS/Fibroids
□ Infertility
□ Pregnant
Child number:_____
Due date: _____

Systemic Conditions:
□ Diabetes: Type_____
□ Cancer: Type_____
□ Epilepsy
□ Thyroid Conditions
□ Allergies: Type_____
□ Osteoporosis
□ Autoimmune Conditions
Type_____
□ Arthritis
Type_____
Where _____
□ Fibromyalgia
□ Chronic Fatigue Syndrome
Family History Yes □ No □

Skin Conditions
□ Allergies
□ Rashes
□ Dermatitis
□ Eczema
□ Acne
Other _____
Family History Yes □ No □

Neurological Conditions
□ Disc Disease
Where: _____
□ Numbness/Tingling
Where: _____
□ Neuralgia/Neuritis
Where: _____
□ Dizziness/Vertigo
□ Headaches (please circle)
migraine / tension / cluster
□ Carpal Tunnel Syndrome
□ Autism Spectrum Disorder
□ Cerebral Palsy
□ Parkinson's
□ Epilepsy
□ Multiple Sclerosis
Other _____

Musculoskeletal Conditions
□ Back pain (please circle)
low / mid / upper
□ Head/Face/Neck pain
□ Bursitis/Tendonitis
□ Joint Dislocation/Instability
□ Jaw Pain/TMJ Syndrome
□ Fractures
□ Muscle Aches/Cramps
□ Scoliosis
□ Joint Pain
Where? _____
□ Other_____

Mental/Emotional Health:
General Mood/Temperament:
_____
□ History of Depression/Anxiety
□ High Stress Levels
□ Trouble Sleeping
□ Eating Disorder

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GENERAL HEALTH AND LIFESTYLE INFORMATION

□ Fatigue □ Loss of Hearing □ Blurred Vision
□ Overweight □ Sedentary □ Smoker □ Alcohol Use
Family History Yes □ No □

Any other pertinent information?

_____
_____
_____
_____
_____

MEDICATIONS - Please list ALL medications you are currently taking and the condition they treat (please include over the counter and prescription drugs).

Medication _____ Condition _____
Medication _____ Condition _____
Medication _____ Condition _____
Medication _____ Condition _____

ACCIDENTS, INJURIES AND SURGERIES- Please list all previous accidents, injuries and surgeries and the treatment received (include motor vehicle accidents, falls, sports injuries, etc. i.e.: fractures, sprains, whiplash, etc. - if more room is needed, please continue on the back of the page).

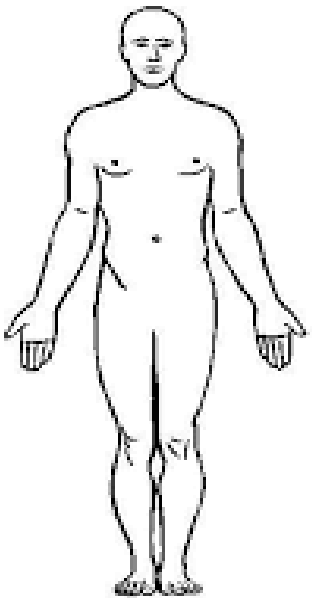
Injury _____ Year _____ Treatment _____
Injury _____ Year _____ Treatment _____
Injury _____ Year _____ Treatment _____
Injury _____ Year _____ Treatment _____
Surgery _____ Year _____ Condition _____
Surgery _____ Year _____ Condition _____

HEALTH CARE PROFESSIONALS - Please indicate if you receive regular treatment or consultation from any of the following individuals:

□ General Practitioner (annual) □ Chiropractor □ Massage Therapist □ Physiotherapist □ Acupuncturist
□ Naturopath □ Homeopath □ Personal Trainer □ Other _____

PLEAS INDICATE AREAS OF CONCERN:

- Circle any areas of concern
- "P" for **PAIN** in the area
- "X" for **JOINT** or **MUSCLE STIFFNESS**
- "#" for **SCARS**, **BRUISES** or **OPEN WOUNDS**
- ≈ - squiggly lines along area of **NUMBNESS** or **TINGLING**



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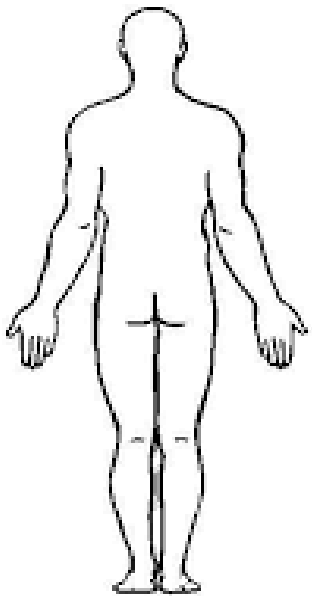

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AGREEMENT

I understand that osteopathic manual practitioners (DOMPs) do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that an osteopathic manual practitioner is not a medical doctor/physician, and that osteopathic manual therapy is not a substitute for medical examination or diagnosis. It is recommended that I see a primary health care provider for that service. I am also aware that there are no guarantees that these treatment(s) will completely relieve the symptoms for which I have consulted.

I agree that it is my choice to receive osteopathic manual therapy. I give permission for Edward Schroeder, DOMP, DScO, to work on all parts of my body, as required and explained, including areas such as the head, neck and spine, tailbone, rib cage and chest, abdomen, pelvis, arms and legs. I understand that parts of the therapist's body may come into contact with mine at times during the treatment. I agree to communicate with my therapist at any time if I feel like my well-being is being compromised or I feel uncomfortable in any way.

I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status. I understand that osteopathic manual therapy is not covered by OHIP. I acknowledge that the clinic/therapist(s) are not responsible for any billing or dealings with private health insurance companies.

CONSENT TO TREATMENT - Please read carefully, and sign and date below.

I declare that I have given the most accurate information to my knowledge, and I understand that the information given will be used to create a personal treatment plan and create a patient file. I understand that the Therapist will give me a full explanation as to the treatment to be provided and any future treatment plans. I therefore give my consent to the Therapist to perform this assessment, and treatment and to collect and use my personal information.

Signature: _____ **Date**: _____

Update 1:_____Date: _____ Update 2: _____ Date: _____
Update 3: _____ Date: _____ Update 4: _____ Date: _____

FEE SCHEDULE (effective January 1, 2020):

- New Adult Patient (1 hour): $160.00
- New Child Patient (45 mins): $120.00
- Subsequent treatments for adults (45 mins): $120.00
- Subsequent treatments for children (30 mins): $ 80.00

CANCELLATION POLICY

Patients are required to provide **24 hours' notice** for any cancellation. Your appointment time has been reserved for you and we appreciate having adequate time to fill the spot. The clinic reserves the right to charge the **FULL FEE** for a missed appointment or an appointment cancelled with less than 24 hours' notice.

CLINIC CONSENT REGARDING PERSONAL INFORMATION AND TREATMENT:

We value the trust you have placed in us and are taking all appropriate measures to safeguard your personal information and confidence. We have established a privacy policy to ensure that your personal information and personal health information is protected. We are committed to protecting the privacy and confidentiality of information we receive or create in the course of serving our patients.

We fulfil this commitment to privacy and confidentiality by complying with the statutory obligations under the *Regulated Health Professions Act, 1991 (RHPA*), and the *Personal Health Information Protection Act, 2004 (PHIPA)*, and by voluntarily adopting the practices set out in its Privacy Code.

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In accordance with our privacy policy, we request that you provide your consent as set out below:

I agree that Tri-City Natural Health Care Centre and Edward Schroeder, DOMP, DScO can collect, use and disclose my personal information and personal health information provided by me in this patient health inquiry history form to provide me with the services I request and for the other limited purposes set out in the *Regulated Health Professions Act, 1991 (RHPA*), and the *Personal Health Information Protection Act, 2004 (PHIPA)*. I hereby give my consent for treatment. I am also aware that Tri-City Natural Health Care Centre and Edward Schroeder, DOMP, DScO, will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered. I acknowledge that Tri-City Natural Health Care Centre and Edward Schroeder, DOMP, DScO, will not be responsible for any lost or stolen personal belongings.

I declare I will inform Edward Schroeder, DOMP, DScO, if there are any changes in my health history, upon my next visit.

I have been advised regarding Tri-City Natural Health Care Centre's **24-hour cancellation policy**, and I authorize a full service charge should this be enforced.

SIGNATURE

I attest that I have read and understood the above information and that the information provided in this form is true and accurate to the best of my knowledge.

Signature: _____ **Date**: _____

Intake Practitioner: _____

Updated: _____ Updated: _____ Updated: _____ Updated: _____ Updated: _____