New Patient Questionnaire

Patient Name: (Mr. /Mrs. /Miss /Ms.) _____
(First Name) (Last Name)

Home Address: _____ Apt No.: _____

City: _____Province:_____ Postal code: _____

Telephone Home: _____ Work: _____ Mobile: _____

E-mail address: _____

Date of birth: _____ Gender: M / F /_____Occupation:_____
Day/Month/ Year

Emergency Contact: _____ Telephone: _____ Relation: _____

How did you hear about us?

□ Walk- by □ Website □ Google
□ Friend □ Facebook □ Other_____

Please help us grow by telling your friends, co-workers and family about us. Your referrals are greatly appreciated.

Patient Health History

What is your chief concern?

_____

Please mark those that apply:

- □ Arthritis
- □ General joint pain
- □ Swollen joints
- □ Numbness/tingling
- □ Elbow pain
- □ Back discomfort
- □ Neck discomfort
- □ Herniated/bulging Disc
- □ Shoulder pain
- □ Wrist/hand pain
- □ Jaw pain
- □ Knee Pain
- □ Hip/leg pain
- □ Bells Palsy
- □ Blurred vision
- □ Earaches
- □ Ringing in ears
- □ Concussion
- □ Heart attack
- □ Heart disease
- □ Stroke
- □ Fatigue
- □ Asthma
- □ Impaired smell/taste
- □ Bronchitis
- □ Cold hands/feet
- □ Headaches/migraines
- □ Hi/Low blood pressure
- Eczema/rash
- □ HIV/AIDS
- □ Shortness of Breath
- □ Hepatitis
- □ Vertigo
- □ Dizziness
- □ Emphysema
- □ Congestion
- □ Diabetes
- □ Digestive issues
- □ Fertility
- □ Cancer: _____
- □ Other:

Current Medications:

_____

_____

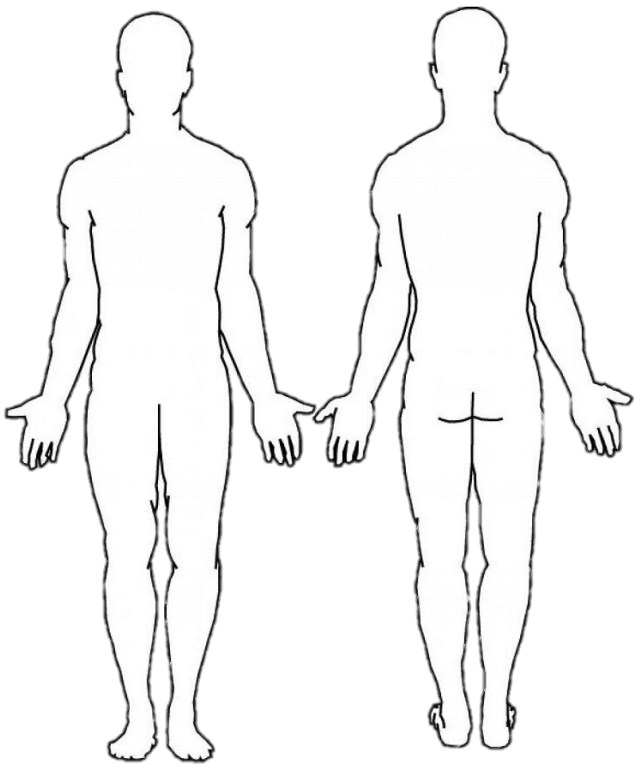
Past surgeries/ trauma/car accidents:

_____

_____

Special considerations (circle those that apply): Pacemaker Rods/Pins/Wires Artificial joints Medication Patch

Other: _____



Patient Signature: _____ Date: _____

If patient is under 16 years of age or if mentally challenged, a parent or guardian must sign below:

I, …… am the parent/guardian of the above named patient and give my full consent for examination and treatment of this patient.

Signature of parent/guardian …….

Osteopathy Consent form

Osteopathy is recognized as one of the safest drug-free, non-invasive therapies available for the treatment of neuro-musculoskeletal and joints complaints. Although 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 osteopathy treatment, but some may experience mild soreness or aching, just as they do after some forms of exercise or massage. Current literature shows that minor discomfort or soreness following therapy typically fades within 72 hours.

INFORMED CONSENT TO OSTEOPATHIC CARE BY CANDICE OHRABLO, DOMP:

I understand that osteopathy is not a substitute for medical treatment and/or medications, and that it is recommended that I work concurrently with my Primary Caregiver for any conditions I have. I am aware that diagnosing conditions is not part of the osteopathic practitioner's scope of practice.

I have had the opportunity to discuss with the osteopathic practitioner any questions or concerns that I have regarding my condition and any forms of therapy to be administered.

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 osteopathic practitioner to anticipate and explain all risks and complications, and I wish to rely on the osteopathic practitioner to exercise their judgment and I understand that all procedures are in my best interests.

I understand that my health information will be treated in confidence.

I am aware of, and agree to, the fee schedule as presented by the clinic.

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: _____ Witness: _____