Perfect Balance
Wellness Centre

Alexandria Patton

HEALTH HISTORY AND CONSENT FORM

Name: _____ E-Mail: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (C) _____ (H) _____ (W) _____

Date of Birth: _____Gender: _____

Allergies: _____

Current Health Issues or Complaints:

_____

_____

_____

History of Complaint:

_____

_____

_____

History of Accidents/Trauma/Surgeries:

_____

_____

_____

Family Medical History (Cancer, Diabetes, High/Low Blood Pressure, Heart Disease, etc.):

_____

_____

_____

Current Medications and For What Conditions (Including Topical, Herbal and Dietary Supplements):

_____

_____

_____

Healthcare Practitioners You Are Seeing:

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____

Any Special Considerations:

[ ] Pacemaker [ ] Rods, Pins, Wires, Screws [ ] Artificial Joints/Limbs [ ] Medication Patch
[ ] Other: _____

Social History:
[ ] Tobacco [ ] Coffee [ ] Drugs [ ] Alcohol
[ ] Other: _____

How Did You Hear About Us?
[ ] Website [ ] Word of Mouth [ ] Advertising [ ] Doctor [ ] Healthcare Practitioner
[ ] Other: _____

Do you have any difficulty with the following (Circle all that apply):

Headaches / Migraines	Dizziness / Vertigo / Fainting	Ringing in Ears / Earaches	Sinus Problems	Sleeping Problems / Disorders
Difficulty Swallowing	Muscle / Joint Pain	Neck / Shoulder Pain	Back Pain (Upper, Mid, Lower)	TMJ / Jaw Pain
Swollen / Stiff Joints	Rheumatoid Arthritis	Osteoarthritis / Osteoporosis	Numbness / Pins & Needles	Cold Extremities
Sensitive Skin / Rashes	Varicose Veins / Phlebis	Deep Vein Thrombosis	Eczema / Psoriasis	Cough / Chest Pain
Stroke / CVA	High / Low Blood Pressure	Heart Palpitations / Disease	Poor Circulation	Aneamia
Inflammation	Poor Digestion / Indigestion	Irritable Bowel Syndrome	Constipation / Diarrhea	Nausea / Vomiting
Kidney / Bladder Dysfunction	Liver / Gallbladder	Chronic Cough	Shortness of Breath	Asthma
Bronchitis / Emphysema	Tuberculosis	Diabetes	Thyroid Dysfunction	Cancer
HIV / AIDS	Hepatitis	Sexually Transmitted Infections / Diseases	Vaginal Infections	Hormone Imbalance
Fibromyalgia	Anxiety / Depression	Fatigue	Prostate Dysfunction	Memory Loss
Cysts / Tumors	Endometriosis / Fibroids	Polyps (Uterine / Colon / Other)	Loss of Taste	Motor / Sensory Loss
Vision Problems / Loss	Hearing Loss	Loss of Smell		

Other: _____

Females:
Menstruation: [ ] Painful [ ] Heavy [ ] Light [ ] Normal [ ] Irregular [ ] Absent
[ ] Pregnant: From _____ to _____
Number of Children: _____
Menopause: [ ] Pre [ ] Active [ ] Post
Breast Tissue: [ ] Swollen [ ] Painful [ ] Cystic [ ] Abnormal Sensation
[ ] Other: _____

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INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I understand that the Osteopathic Manual Practitioner (OMP) is providing Osteopathic Manual Therapy within their scope of practice. I hereby consent to the OMP treating me with Osteopathic Manual Therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my OMP.

I understand that treatments include manual therapies where the OMP places their hands on my body. Many techniques will involve contact between your body and the OMPs body. Body and hand contact may include areas of your chest wall, pelvic floor, pelvic bones, etc. No intra-oral work is required.

I understand that the OMP may ask you to remove outer, bulky clothing in order to better facilitate treatment.

I understand that if I do not feel comfortable at any part of the treatment, I will communicate this to the OMP immediately. The techniques can be discontinued or modified to be comfortable for me. I understand that I can discontinue treatment at any time, as well as can the OMP.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks, those risks have been explained to me, and I assume those risks.

I understand that the OMP must be fully aware of my existing medical conditions. I have completed my health history form provided to the best of my ability and I have disclosed all medical conditions affecting me. It is my responsibility to keep the OMP updated with any medical changes immediately (before treatment commences). I have been cleared by my doctor before Osteopathic treatment.

I understand that this is a confidential record of my medical history and will be kept safe in this office. The information contained in it will not be released to any person unless you authorize the OMP to do so. The health information requested on this form will assist the OMP in treating me in the most efficient and safest way possible. And my written permission is required to release any information, unless the OMP is required by law.

I authorize the OMP to release information to third party payers, such as during the claiming of benefits from a third party.

I understand that I am required to provide 24 hours notice for any cancelled or re-scheduled appointments. If I cancel with less than 24 hours notice, I will be charged for the treatment, and I will pay for that treatment at the next treatment I attend.

I have read the above and have had the opportunity to question the contents and the therapy. By signing this form, I have given my consent to the above and consent to treatment. By re-booking, I am giving my consent to all subsequent treatment. I am not aware of any reason that would prevent me from receiving Osteopathic treatment. If my health changes and the answers to any of the above questions change, I agree to immediately inform my Osteopathic Manual Practitioner.

Signature: _____ Date: _____