CompleteCare CHIROPRACTIC

Osteopathic Intake Form

Personal Details

Name: _____ Gender: ☐ M ☐ F Birthday (D/M/Y) _____/_____/_____

Home Address: _____ City: _____ Postal Code: _____

Telephone (Home)_____ (Work)_____ (Mobile)_____

E-mail address _____

Emergency Contact:_____ Relationship: _____ Phone _____

Medical Doctors Name: _____ Last Visit: _____/_____/_____

How did you hear of this practice? _____

How would you like to communicate with our clinic? ☐Email ☐Cell Phone ☐Home Phone ☐Work Phone

Please indicate if your injuries are related to a work/car accident: ☐Neither ☐ Work Related ☐ Car Accident

Medical History

1. Please list all current medications (including vitamins etc): _____

_____

2. Have you ever experienced any major accidents/injuries, broken bones, or dislocations? List Details. _____

3. Have you ever had any surgeries/Hospitalizations? List Details. _____

_____

4. In the past 5 years, have you had: ☐X-Ray ☐CT Scan ☐MRI ☐Ultrasound ☐ Blood Tests ☐Other

List details: _____

5. Have you ever experienced any of the follow, or other medical illnesses?

☐HIV	☐Hepatitis	☐Stroke	☐ Heart Attack	☐ Hypertension	☐Varicose Veins
☐DVT	☐Pacemaker	☐ Rheumatic Fever	☐ Pneumothorax	☐ Asthma	☐Chronic Bronchitis
☐COPD	☐ Emphysema	☐ Tuberculosis	☐ Epilepsy	☐ Multiple Sclerosis	☐Depression
☐Anxiety	☐ Polio	☐ Syphilis	☐ Meningitis	☐ Parkinson's	☐Arthritis
☐Cancer	☐Osteoporosis	☐ Kidney Stones	☐Urinary Infections	☐ Hemorrhoids	☐Thyroid Disease
☐ Diabetes	☐Anemia	☐Food Allergies	☐Seasonal Allergies	☐Other allergies: _____	

☐Other conditions: _____

Family History 6. Has anyone in your family suffered from any conditions/diseases/illnesses?

☐Diabetes ☐Hypertension ☐Stroke ☐Heart Disease ☐Arthritis ☐Migraine ☐Cancer

☐Other: _____

Social History

7. Do you drink alcohol? ☐ Yes ☐ No Drinks per week: <1 1 2 3 4 5 6 7 8 9 10 >10

8. Do you smoke cigarettes? ☐ Light Smoker ☐ Heavy Smoker ☐ Former Smoker ☐ No/Never

9. Cigarette Packs per Day: <1 1 2 3 4 5 6 7 8 9 10 >10

10. Do you drink coffee/caffeine? ☐ Yes ☐ No Drinks per day: <1 1 2 3 4 5 6 7 8 9 10 >10

11. Do you exercise: ☐ No ☐ Light Exercise ☐ Moderate Exercise ☐ Strenuous Exercise

12. How many hours per week do you exercise: <1 1 2 3 4 5 6 7 8 9 10 >10

Workplace History

13. Employer: _____ Occupation: _____

14. Please check the most accurate description of your overall work demands.

☐Sedentary (sitting) ☐Standing ☐Light Labor ☐Heavy Labor

15. Please check the boxes that accurately describe the procedures you perform at work.

☐Sitting ☐Standing ☐Walking ☐Squatting ☐Bending ☐Stairs ☐Jumping
☐Climbing ☐Kneeling ☐Crawling ☐Pushing ☐Pulling ☐Overhead Work
☐Desk Work ☐Lifting up to 25lbs ☐Lifting 25 to 50lbs ☐Lifting 50 to 100lbs ☐Lifting >100lbs
☐Other: _____

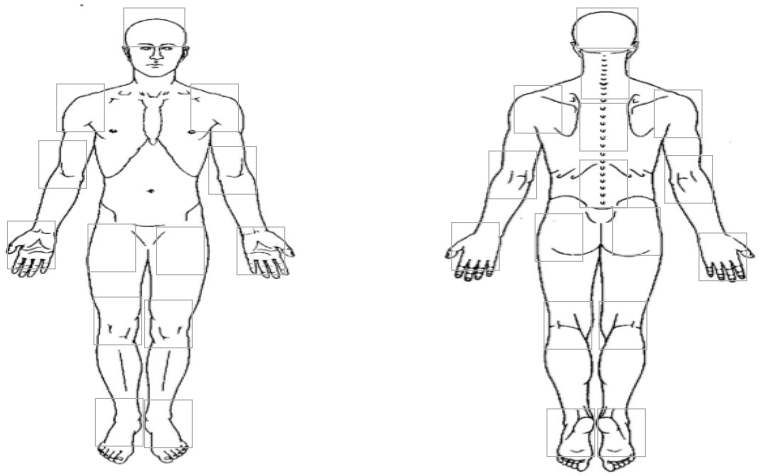
Chief Complaint

16. Indicate the concerns that you are seeking care for today. Please indicate the most significant issues (in order).

1. _____

2. _____

3. _____



Systems Review 17. Are you experiencing any of the following?

General
☐New mole
☐Change in Mole
☐Rashes
☐Discolorations
☐Bleeding
☐Bruising
☐Fatigue
☐Muscle Aches
☐Joint Pain
☐Weakness
☐Numbness
☐Leg Cramps
☐ Leg Swelling

Gastrointestinal
☐Heart Burn
☐Bloating
☐Nausea
☐Vomiting
☐Constipation
☐Diarrhea
☐Aggr. by food
☐Aggr. by drinks

ENDO
☐Excessive Thirst
☐Change in Appetite
☐Temp Intolerance

EENT
☐Ringing in Ears
☐Ear Pain
☐Balance Issues
☐Jaw Issues
☐Sore throat
☐Glasses/contacts

CSV/RESP
☐Palpitation
☐Cough
☐Chest Pain
☐Difficulty Breathing

NVS
☐Mood changes
☐Memory Loss
☐Seizures
☐Sleep Issues
☐Tremors/Shakes
☐Nervousness

URINARY
☐Painful Urination
☐Burning
☐Discoloration
☐Blood in Urine
☐Incontinence

FEMALE ONLY
☐Breast Lump
☐Mid Cycle Bleed
☐Irregular Periods
☐Vaginal Discharge
☐Vaginal Bleeding
☐Pregnant
☐Birth Control
☐Hormone Therapy

MALE ONLY
☐Bleeding
☐Scrotal lump
☐Scrotal swelling

Red Flags

18. Are you currently experiencing any of the following?

☐Recent Infection ☐Fever ☐Chills ☐IV Drug Use ☐Steroid Use ☐Alcohol Abuse ☐Osteoporosis ☐Cancer

☐History of Cancer ☐Weight Loss ☐Night Pain ☐Night Sweats ☐ Blood In Stools ☐Change In Bowel Habits

☐Decreased bowel control ☐Change in Urination ☐Deep Pain In Abdomen ☐Heartbeat Sensation in Stomach

☐ Recent Fainting ☐ Recent Dizziness ☐ Trouble Talking ☐ Trouble Swallowing ☐ Double Vision ☐ Numbness

☐New Headache (If age > 40) ☐Change in Headache ☐change in vision ☐change in hearing ☐change in taste

☐Change in smell ☐Cognitive changes ☐Loss Of Consciousness ☐Severe Headache that peaks in Seconds

Yellow Flags

19. Please check the boxes that apply to you.

☐ I have problems at work ☐ I am not happy with my job ☐ I work Shift Work ☐ I have missed work due to pain

☐ I avoid socializing due to pain ☐ I believe that pain is harmful ☐ I avoid activity due to pain

☐ I rest until the pain is gone ☐ I believe that my pain will improve ☐ I believe that my pain will not improve

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Intake Form Acknowledgement

I acknowledge and confirm that the above information is correct and true. I also provide my consent to allow the health practitioner to perform the exams/tests that he/she deems clinically relevant to come to a diagnosis and/or plan of management. I hereby authorize Complete Care Chiropractic, with my prior knowledge, to release or to obtain any health information to/from my other health care providers as may be required for the diagnosis/management of my case. **To be signed after consultation.

Sign:_____ (Patient/Guardian) Date: _____ / _____ / _____

Informed Consent to Osteopathic Care

Important Aspects to Note

Osteopathic care can help reduce pain in your neck, back, torso and other joints as well as provide relief from headaches and pregnancy related back pain. Osteopathic care can also help improve movement, flexibility, posture and gait, and can help to prevent muscle and joint injuries.

While rare, some patients may experience short term aggravation of symptoms or muscle/ligament sprains or strains as a result of manual therapy technique.

Although uncommon, rib fractures have known to occur following certain manual therapy procedures.

Although rare, there have been reported cases of disc injuries following cervical and lumbar spinal manipulation, however no scientific evidence has demonstrated that these injuries are caused by osteopathic treatment.

There are reported cases of stroke associated with visits to several healthcare providers. However research and scientific evidence does not establish a cause and effect relationship between manual therapy and stroke. Recent studies suggest that patients may be in the early stages of stroke while consulting with a health care professional. It is important to be aware that stroke may cause neurological impairment or even death, however the possibility of such injuries due to osteopathic treatment is extremely remote.

There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some manual osteopaths.

Alternatives to Osteopathic Care.

There are other alternatives to osteopathic care including seeking medical advice, chiropractic care, massage therapy, physiotherapy, acupuncture etc. However, keep in mind all therapies have their own risks associated with them. You also have the option of doing nothing. Although the symptoms have a tendency to improve without treatment, this is not advised as there is an increased chance of re-occurrence in the future.

Osteopathic Fees

I understand there are fees associated with osteopathic care and the fees relative to my care have been explained. I agree to this proposed fee schedule and understand that I am responsible for payment of these fees at each visit.

Consent

I acknowledge I have read this consent and I have discussed with my manual osteopath the nature and purpose of osteopathic treatment, the treatment options and recommendations for my condition, and the contents of this consent. I understand written consent is required before treatment, however can be withdrawn anytime. I consent to the osteopathic treatment recommended to me by my manual osteopath. I intend this consent to apply to all my present and future osteopathic care. **To be signed after consultation.

Date: _____ / _____ / _____

Print:_____ (Patient/Guardian) Sign:_____ (Patient/Guardian)

Print:_____ (Practitioner) Sign:_____ (Practitioner)