My Toronto Osteopath

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Confidential Patient Information

Last Name _____ First Name_____ Date of Birth (YYMMDD) _____

Address _____ City/Province _____ Postal Code _____

Mobile Phone_____ Email _____ Occupation_____

Insurance/Extended Healthcare Provider: _____

How did you learn about My Toronto Osteopath? _____

Medical History

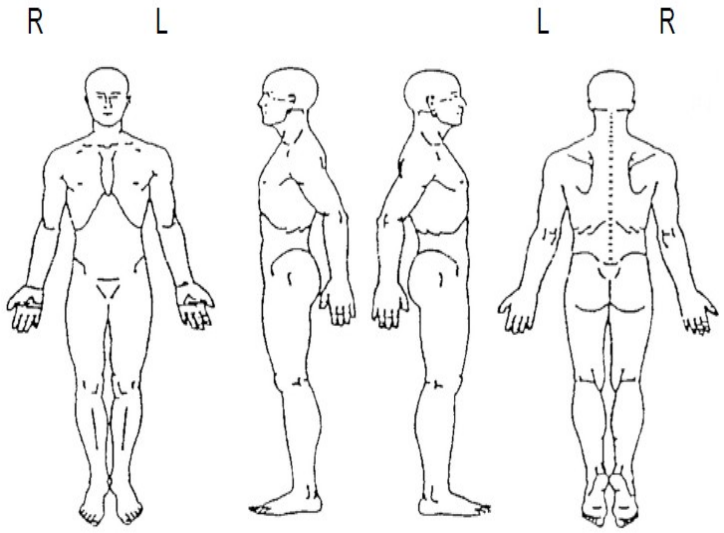
Which of the following apply to you?

- ☐ Heart Disease
- ☐ Hernia
- ☐ Headache
- ☐ Cramps
- ☐ Fainting
- ☐ Hypertension
- ☐ Diabetes
- ☐ Ulcers
- ☐ Infection
- ☐ Insomnia
- ☐ STI
- ☐ Epilepsy
- ☐ Cancer
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Atherosclerosis
- ☐ Nervousness
- ☐ Varicose Veins
- ☐ Surgical Implants
- ☐ Urinary Disorder
- ☐ Constipation
- ☐ Arthritis
- ☐ Dizziness

Have you had surgery done? ☐Yes ☐No
Nature of surgery:
Date of Surgery

Are you currently pregnant? ☐Yes ☐No

Indicate on the diagram where you feel discomfort.



Main Complaint(s): _____

Other Complaint(s): _____

Type of pain: _____ **What relieves the pain?** _____

Have you suffered any injuries or illness? _____

Describe injury/illness (if applicable)

_____

_____

Date of injury (if applicable) _____
(YYMMDD)

Informed Consent for Osteopathy and Massage Therapy

I give my full and voluntary consent to osteopathic treatment by a qualified osteopathic manual practitioner. The practitioner has thoroughly explained alternative treatment where applicable and relevant, and the possible risks and side-effects of the proposed treatment plan.
I understand that I may stop treatments at any time. At any given time throughout my treatments, I may request the practitioner to stop, modify or change the treatment plan. Inappropriate actions or language is cause for termination of treatment. The practitioner reserves the right to refuse service to anyone.

I acknowledge and understand that the Osteopathic Manual Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Therapist and have disclosed to the Osteopathic Manual Therapist all of those medical conditions affecting me**. It is my responsibility to keep the practitioner updated on my medical history.** The information I have provided is true and complete to the best of my knowledge.

I understand the fee schedule, and that payment is due when services are rendered along with any other statements pertaining to pay schedules. I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, the nature of and treatment in general, the treatment options and recommendations for my condition and the contents of this Consent.

I understand that failure to notify the practitioner or reception of inability to attend my scheduled appointment 24 hours in advance may result in a charge of the full price of your session.

I have read the above and understand the consent to the above terms and to the osteopathic and/or massage therapy treatment.

Patient's Signature: _____ Date: _____

Practitioner's Signature: _____ Witness: _____

Thank you for entrusting us with assisting you in your wellbeing.