CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let us know.

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

Address _____ City/Province _____ Postal Code _____

Cell Phone _____ Email _____ Occupation _____

Insurance/Extended Healthcare Provider: _____

How did you learn about My Toronto Osteopath? ☐ Google Search ☐ Friend ☐ Doctor Referral ☐ Insurance Site

☐ Facebook or Instagram ☐ Other: _____

Are you currently receiving treatment from another healthcare provider? ☐Yes ☐No

Have you had Osteopathic treatment in the past? ☐Yes ☐No

Have you had Massage Therapy treatment in the past? ☐Yes ☐No

Medical History

Which of the following apply to you?

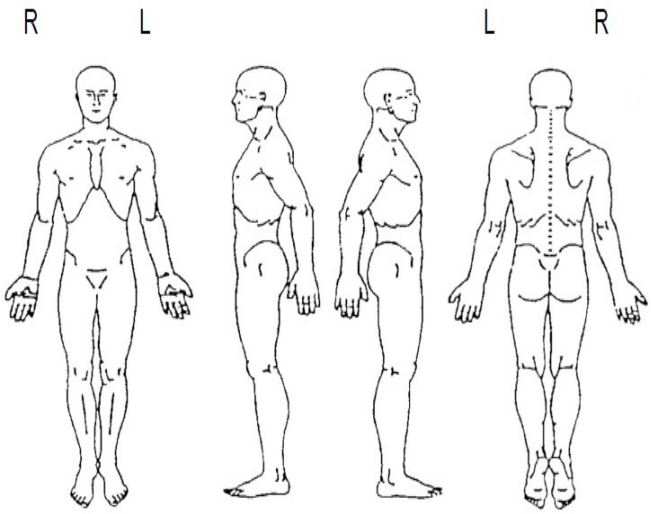
☐ Heart Disease	☐ Insomnia	☐ Nervousness
☐ Hernia	☐ STI	☐ Varicose Veins
☐ Headache	☐ Epilepsy	☐ Surgical Implants
☐ Cramps	☐ Cancer	☐ Urinary Disorder
☐ Fainting	☐ Stroke	☐ Constipation
☐ Hypertension	☐ Osteoporosis	☐ Arthritis
☐ Diabetes	☐ Atherosclerosis	☐ Dizziness
☐ Ulcers	☐ Shortness of Breath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

Do you have any allergies? ☐Yes ☐No
Nature of Allergy(ies): _____

Have you had surgery? ☐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)

Date of initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

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Informed Consent for Osteopathy and Massage Therapy

I _____FIRST NAME_____ _____LAST NAME_____ 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 my 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: _____

Complete if patient is under 18 years old:
Guardian's Signature: _____ Date: _____
Relationship to patient: _____ Contact Number: _____

Thank you for entrusting us with assisting you in your wellbeing