Manual Osteopathic Therapy Intake Form

Full Name: ____ Date: _____________________________

Address: ____

Date of birth: ____________________________________ Phone: _____________________________________

Email address: ____

How did you hear about us? ______________________Occupation: _____________________________________

What are your goals for today's treatment? ____

Health History

Have you had a manual osteopathic treatment before? ___Yes ___No

If yes, for what? ____

Are you currently being treated by a Chiropractor or Physical Therapist? Yes / No

Any injuries within the past 72 hours? ___Yes ___No Explain______________________________________

Past Surgeries and dates____

____

Medications/ Supplements/ Drugs____

Allergies____

Please indicate Current conditions with a **C** and Previous with a **P**:

Respiratory:

_____ Chronic cough
_____ Shortness of breath
_____ Bronchitis / Asthmas
_____ Sinus infections
_____ Emphysema
_____ Smoke / Vape

Cardiovascular:

_____ Cool hand / feet
_____ High / low blood pressure
_____ CCHF or Heart Attack
_____ Varicose veins of phlebitis
_____ Poor healing of wounds
_____ Stroke / CVA
_____ Pacemaker or other devices
_____ Swelling in hands / feet

Skin:

_____ Bruise easily
_____ Rash / open, sore / warts
_____ Sensitivities / allergies: _______________________
_____ Contagious skin disease

Digestive:

_____ Constipation
_____ Nausea / vomiting
_____ Ulcers/blood in stool
_____ Liver/Kidney problems
_____ Quick weight loss / gain
_____ Appetite changes
_____ Ulcerated colitis / Crohn's/IBS

Infections:

_____ Hepatitis
_____ Tuberculosis
_____ HIV

Head and Neck:
____ Tension / migraine headaches
____ Tinnitus (ringing in ears)
____ Tooth / jaw / ear pain
____ Vision problems/loss
____ Hearing loss
____ Dizziness / lightheaded
____ Other: ______________________________

Soft tissue/Joint/Nerve:
____ Fibromyalgia
____ Arthritis ____RA ____OA,
area(s): ______________________________
____ Herniated disc(s) Level: __________________
____ Osteoporosis
____ Fracture, area: ________________________
____ Thoracic Outlet Syndrome
____ Head trauma / concussion
____ Whiplash/car accident
____ Neck pain / stiffness / injury / numbness
____ Shoulder pain / stiffness / injury
____ Arm pain / weakness / tingling,
area(s): ______________________________
____ Back pain / stiffness / injury
____ Leg pain / weakness / injury / tingling,
area(s): ______________________________
____ Knee or foot pain / injury
____ Tendonitis / Tenosynovitis
____ Bursitis or dislocations
____ Sport / work related injury
____ Carpel tunnel syndrome

Women:
____ Pregnant (due: ________________________)
____ Painful menstruation
____ Hysterectomy
____ Birth control
____ IUD inserted
____ C-section, how many: ____________________

Other conditions:
____ Loss of sensation
____ Diabetes (onset / type: __________________)
____ Epilepsy
____ Insomnia
____ Depression / Anxiety
____ Multiple Sclerosis
____ Cancer (onset / type: ___________________)
____ Other: ______________________________
____
____

Other Questions:
____ I get a good night sleep
____ I eat a well-balance diet
____ I have low energy
____ I feel good about life
____ I have high stress level

Additional information: ____

Current Condition:

Please describe your current pain____

____

How long have you had this pain? ____

How did it start: ____

What aggravates it: ____

What relieves it: ____

Signature: ____

Date: ____

Therapist: ____

INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I understand that the Manual Osteopathic Therapist is providing osteopathic manual therapy within their scope of practice.

I hereby consent to my Manual Osteopathic Therapist to treat me with Manual Osteopathic therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Manual Osteopathic Therapist.

I understand that treatments include manual therapies where the Manual Osteopathic Therapist places his/her hands on your body. Many techniques will involve contact between your body and the Manual Osteopathic Therapist's body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones. If intra-oral work is required, disposable latex or vinyl gloves will be worn.

I understand that the Manual Osteopathic Therapist may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The techniques can be discontinued or modified to be comfortable for you.

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 and those risks have been explained to me and I assume those risks.

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

I authorize my Manual Osteopathic Therapist to release or obtain information pertaining to my conditions(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Manual Osteopathic Therapist from time to time, to deal with my physical, emotional, and mental conditions and for which I have sought treatment.

Initial: ________

Manual Osteopathic Therapist's Name: ______________________________

Date: ______________________________

Print Name: ______________________________

Signature: ______________________________