Patient Intake Form

NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____ DOB (M/D/Y): _____/_____/_____

AGE: _____ OCCUPATION: _____

HOME #: _____ WORK #: _____

CELL #: _____ EMAIL: _____

PREFERRED METHOD OF CONTACT: _____

EMERGENCY CONTACT: _____ PHONE: _____

FAMILY PHYSICIAN: _____ PHONE: _____

REASON FOR TREATMENT: _____

How did you hear about us? _____

Christie Integrated Health Centre places the safety and well-being of the patient first. Prior to the patient's initial treatment we require patients be informed of and consent to the following terms and agreements.

Terms of Treatment

1. All information recorded on the health history form is essential to giving you the most effective and safe treatment possible. In signing this form you understand that everything discussed and/or recorded is strictly confidential and no information may be released or discussed with anyone without your consent.
2. As a new patient it is necessary to have a complete assessment performed. This is required so that a relevant, safe and effective treatment can be provided for you. New health history forms and full physical assessments must be revised after a long duration away from treatment, or if your health status changes dramatically. Due to the nature of osteopathic manual therapy, please bring appropriate clothing such as shorts and a T-shirt so that you may be properly treated.
3. Payments can be made by debit, cash, cheque, or Interac e-transfer.
4. Missed appointments without 48 hours' notice will be issued a full charge of the time scheduled, except in the event of a family emergency or illness.
5. Please arrive 10 minutes prior to your scheduled appointment time so you may change into appropriate clothing and be ready for your treatment. In the case of late arrivals it is fully understood that only the time remaining for your scheduled appointment will be allotted unless additional time is available. It is not office policy to provide reminder calls prior to your appointment.
6. It is not the policy of this clinic to work through WSIB or MVA claims
7. Clients under the age of 18 must have a parent or legal guardian accompanying them for the initial assessment / treatment and must co-sign this document. If a client is under the age of 16 a parent of legal guardian must be present for all assessments and treatments that may follow.

I hereby understand and accept all the above terms, agreements and cautions. I voluntarily give my consent to my practitioner to proceed with his/her diagnosis and treatment. This consent includes any future clinic diagnosis and treatments.

DATE____/_____/ _____ SIGNATURE: _____

PARENT/GUARDIAN (if patient is under 18): _____

Patient Assessment Form

PATIENT NAME: _____

CHIEF COMPLAINT: ROS:

HX (history) OF CHIEF COMPLAINT:

DIAGNOSTIC STUDIES & TEST RESULTS:

ALLERGIES:

MEDICINES & SUPPLEMENTS:

MEDICAL HX:

SURGICAL HX:

PAST ACCIDENTS/INJURIES:

SOCIAL HX: Tobacco Alcohol Drugs Caffeine

MARITAL HX:

OCCUPATIONAL HX:

FAMILY HX:
Mother: Siblings:

Father: Children:

HEIGHT: _____ WEIGHT: _____ BMI (wt/ht2 X *704.5): _____ BP: _____HR: _____

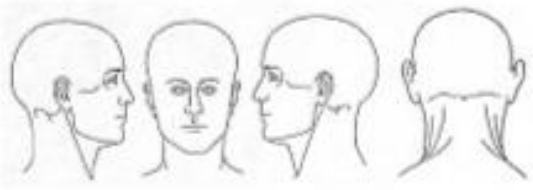
*<u>***For the practitioner only***</u>*

NEURO EXAM:

ORTHO EXAM:

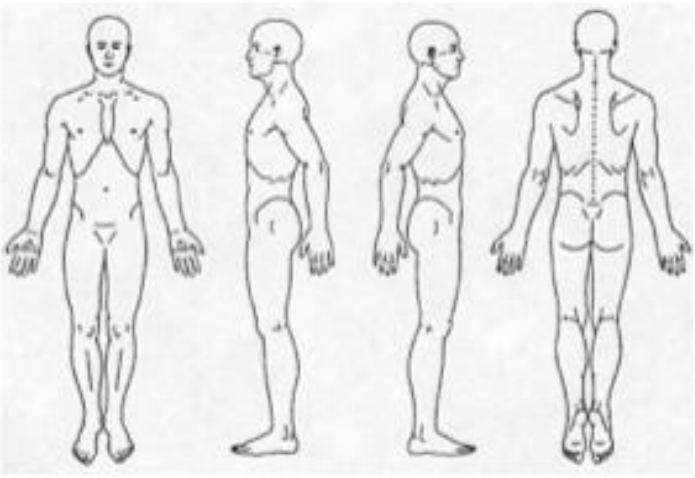
FINDINGS BY REGION: Asymmetry / Restricted or Altered Motion / Tissue Texture Changes / Sensorial Changes

CRANIAL



CERVICAL

UPPER EXTREMITY



THORACIC/RIB CAGE

ABDOMEN/VISCERAL

LUMBAR SACRAL

HIP/PELVIS LOWER EXTREMITY

OTHER FINDINGS:

ASSESSMENT:

PLAN:

DATE: _____/_____/ _____ SIGNATURE: _____