Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____Date of Birth (DD/MM/YY): _____
Address:_____
Phone number:_____ Email: _____
Occupation: _____
Have you received osteopathic therapy before? ☐Yes ☐No

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
☐ high blood pressure
☐ low blood pressure
☐ chronic congestive heart failure
☐ heart attack
☐ phlebitis / varicose veins
☐ stroke/CVA
☐ pacemaker or similar device
☐ heart disease

is there a family history of any of the above? ☐Yes ☐ No

Respiratory
☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections
☐ hepatitis
☐ skin conditions
☐ TB
☐ HIV
☐ herpes

Other Conditions
☐ loss of sensation, where?
_____
☐ diabetes, onset:
_____
☐ allergies / hypersensitivity to what?
_____
type of reaction:_____
☐ epilepsy
☐ cancer, where?
_____
☐skin conditions, what?
_____
☐arthritis
is there a family history of any of the above? ☐ Yes ☐ No

Head/Neck
☐ history of headaches
☐ history of migraines
☐ vision problems
☐ vision loss
☐ ear problems
☐ hearing loss

Women
☐ pregnant, due:_____
☐ gynaecological conditions, what?_____

Overall, how is your general health?
☐Poor ☐Fair ☐Good ☐Excellent

Primary Care Physician:
_____
Address/Contact:
_____
_____

Current medication/supplement	Condition it treats

Are you currently receiving treatment from another health care professional? ☐Yes ☐ No

Type of practitioner	Condition treated

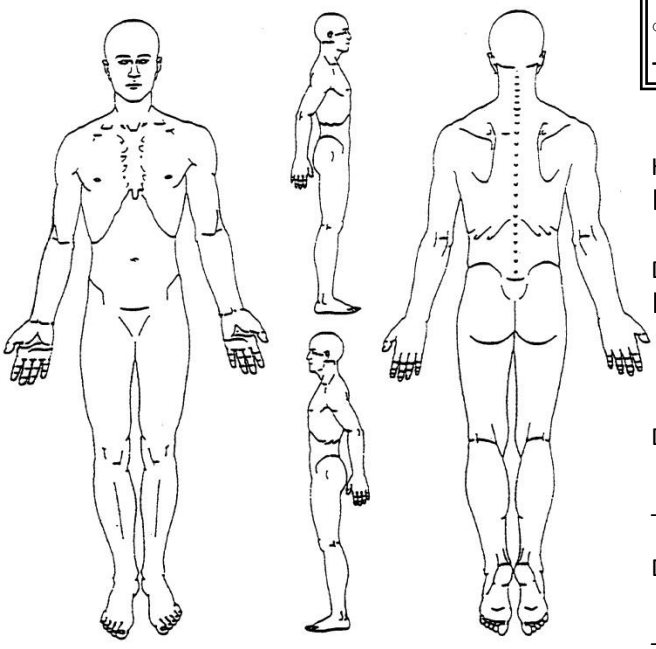
Surgery/Injury/Hospitalisation	Date

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)?
☐ Yes ☐ No? Please, list if any_____
_____
_____

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No
what? _____
where? _____

What is the reason you are seeking osteopathic therapy?
_____
_____
_____

Please indicate areas of pain/discomfort using symbols:



/// TIGHTNESS @ TENDER POINT X PAIN

○○○ NUMBNESS SWELLING +++ TINGLING

--- WEAKNESS ___ OTHER: _____

How would you describe the pain: ☐ Dull ☐ Sharp
☐ Constant ☐ Radiating ☐ Other _____

Does the discomfort interfere with your daily activities:
☐ Yes ☐ No

Do you sleep well? ☐ Yes ☐ No

Does anything aggravate the pain? _____

_____

Does anything relieve the pain? _____

_____

Late Arrival / Cancellation Policy

I understand that I will be charged a fee (up to the full session fee) for any missed appointments or late cancellations, and am required to notify at least 24 hours in advance of my cancellation. I understand that late arrival reduces my treatment time and that full session fee will apply when a late arrival does occur.

Consent to Treatment

I hereby voluntary request to the performance of Osteopathic Therapy treatment on me by the Osteopath – Manual Practitioner Sasa Marinkovic ("DOMP").
It is my responsibility to disclose to the DOMP all medical conditions affecting me and to keep the DOMP updated on my medical history. I acknowledge and understand that the DOMP must be fully aware of my existing medical conditions.
I have been explained and I fully understand the purpose of assessment. I have been explained and I fully understand the risks, side effects and benefits of the Osteopathic Therapy techniques included but no limited to soft tissue and joint mobilisations, myofascial release, and use of modalities (including but not limited to ultrasound and laser).
I have had an opportunity to ask questions. I understand that I can stop the assessment / treatment at any time.
I do not expect the DOMP to be able to anticipate and explain all possible risks and complications and side effects of treatment, and I wish to rely on the DOMP to exercise judgment during the course of treatment which the DOMP thinks at the time, based upon the facts then known is in my best interest.
By voluntarily signing below I show that I have read, or have had read to me, and understand and fully agree to this Consent and Late Arrival / Cancellation Policy.
I intend this Consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from DOMP Sasa Marinkovic.
I acknowledge and declare that I am aware and fully agree to all of the above. Date:_____

Client name: _____ Signature:_____

DOMP use only:

DOMP Signature: _____ Date:_____