PATIENT HISTORY

Today's date	Date of birth .....
Name	Occupation .....
Address	Sports & activities .....
Home phone	GP name & location.....
Mobile phone	.....
E-Mail	Person to contact in case of emergency .....
How did you hear about this clinic?	.....
.....	Contact no.....

Please mark on the diagram where your symptoms are today and differentiate between pain, numbness, tingling and other

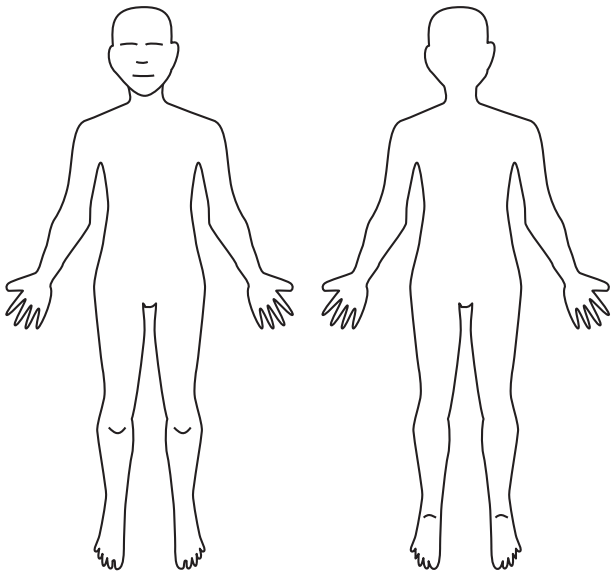
Is your pain sharp, burning, dull, ache, vague, localised (circle)

Is your pain superficial, muscular or deep (circle)

Please write other current or previous symptoms

.....

.....



On a scale of 1-10 , where would you rate your current level of pain?
0-1-2-3-4-5-6-7-8-9-10 excruciating (circle)
When did the pain start?.....
What were you doing when the pain started? .....
Has it happened before? Y/N When? ..... How frequently? .....
Is it now better, worse or stable (circle) Is it constant or intermittent (circle)
What initiates or worsens the symptoms? .....
What relieves or improves the symptoms?.....
Have you had any previous treatments for the above mentioned symptoms?
If so, what? .....
Have you had any previous investigations for the above? X-Ray, MRI, CRT, Blood tests, other (circle)
Does the pain reduce in different positions? Y/N
Does the pain wake you at night? Y/N
Do you have night sweats? Y/N
Any unexplained weight loss? Y/N
Do you have a previous history of cancer? Y/N
Change or difficulty in bladder/bowel function? Y/N

PLEASE COMPLETE OTHER SIDE OF THIS FORM

General Health

How would you rate your general health: Poor / Fair / Good / Excellent

How would you rate your Diet? Poor / Fair / Good / Excellent

How would you rate your work, home life and other stress: Low / moderate / increased stress

Alcoholic drinks per week?..... Cigarettes per week?.....

Please tick if you have previously suffered or are currently diagnosed with any of the following:

☐ Headaches	☐ Cancer.....	☐ HIV/AIDS	☐ Fatigue
☐ Dizziness	☐ Arthritis.....	☐ Hepatitis	☐ Anxiety
☐ Tinnitus	☐ Diabetes.....	☐ Epilepsy	☐ Depression
☐ Fainting	☐ Osteoporosis.....	☐ Allergies	☐ Insomnia
☐ High blood pressure	☐ Psoriasis.....	☐ DVT	☐ Chest pain
☐ Bloating	☐ Heart problems.....	☐ Asthma	☐ Infections
☐ Reflux/indigestion	☐ Kidney problems.....	☐ Stroke	☐ Swelling of joints
☐ Menstrual pain	☐ Thyroid problems.....	☐ Clotting disorder	☐ Pneumothorax

☐ Other diseases/symptoms (please list).....

☐ Do you have a family history of cancer or any of the above diseases (please list) .....

.....

Previous trauma/injuries or car accidents? (list when and details) .....

.....

Any surgery/hospitalisations? (list when and details).....

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Please list all current medications, what they are prescribed for and when you started taking them (especially note any anti-inflammatory, steroid or anticoagulant drugs).....

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Please list any other over the counter supplements you are currently taking .....

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Number of children? ..... Are you currently pregnant? Y/N

Any difficuties encountered during pregnancy or labour?.....

Other gynaecological issues (list & describe).....

Privacy note and Consent to Osteopathic care

We collect your health information only with your consent as necessary for the proper effective treatment of your condition. We treat this information in strict confidence and unless we are legally obliged to do so, we will not release it to a third party without your consent.

You may access this information with your treating practitioner at any time. If you have any concerns regarding the confidentiality of your information, feel free to discuss these with your practitioner.

Osteopathic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures which you should be informed about.

Please read the following carefully

1. I acknowledge that I have discussed with my practitioner the rare risks associated with my proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes), pneumothorax, disclocation of joints, paralysis, nerve damage, bleeding, bruising, inflammation, infection and an exacerbation and/or aggravation of my underlying condition.
2. I have had the opportunity to discuss the proposed care with my practitioner. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed osteopathic care and that I have been given sufficient time to make a decision giving consent for care to proceed.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
4. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
5. I hereby acknowledge my consent to the performance of the proposed osteopathic care by the practitioner and or any other osteopath working in this clinic. I understand that I can withdraw consent at any time.

patient name..... signature..... date.....

(Parent or Guardian to also sign if patient is dependent/under 18 years of age)