Patient Intake Form

Contact info

First name_____ Last name_____ Parent/Guardian name_____
Birthday (mm.dd.yy.)_____ Gender_____ Address_____City _____
Postal code_____ Phone(10 digits)_____ E-mail _____
Emergency contact _____Occupation_____
Insurance _____How did you find us? _____

Patient history

Reason of appointment: Wellness (will not cover by insurance), Treatment, Chronic condition, Acute condition
Main complains:_____When it starts? _____
Possible reasons of your condition? _____
Anything that provides relief?_____
List all your medications_____
Home environment _____
Work environment _____
Environmental exposures(smokers,pets,noise,etc.) _____
Pain level (from 1-lowest to 10-highest)_____ Stress level (from 1-lowest to 10-highest)_____
Allergies _____
Your MD contacts_____ Treatment from the other practitioners (name, field, results) _____

Patient History (mark events that had place)	Living Habits (indicate what applies to you)	Health history (mark disorders that you have)	Present Condition (mark symptoms that you have)	Problem locations (indicate what applies to you)	Check about possible contraindications (indicate what applies to you)
- Whiplash injury - Car accident - Hard fall onto your back (buttocks) - Hard blow to your head (concussion) - Pin,plate or screw in your body - Surgeries (describe below) - Major illnesses, injuries(describe below) - Stressful job, events, life - C-section - Office sitting job - Emotional trauma - Pacemaker Problems with: - vision/eyes - reading/writing -attention/ concentration - memory/spelling - headaches/ coordination - Other details (describe below)	- Sport, physical exercises - Natural food - Positive emotions - Purified water - Active rest - Hobbies - Tobacco - Alcohol - Marijuana - Electronic devices addiction - Narcotics - Sugar - Coffee - Late night eating - Fast food - Physical inactivity - Salt - Other habits (describe below)	- Allergies - Diabetes - Haemophilia - Cancer - Scoliosis - Heart disease/problem - High/low blood pressure - Stroke/CVA - Asthma - Depression - Thyroid disease - Fibromyalgia - Epilepsy - Migraine - Hepatitis - HIV/AIDS - Venereal diseases - Tuberculosis - Arthritis - Skin conditions - Plantar fasciitis, bone spurs - Osteoporosis - Gynecological conditions - Lyme disease - Other Diagnosis (describe below)	- Dizziness - Weakness - Cold hands/feet - Numbness - Balance problems - Nausea, vomiting - Shortness of breath - Headaches - Difficulty sleeping/insomnia - Weight loss/gain - Bowel, bladder disfunction - Ear, throat or sinus problems - Loss of consciousness - Convulsions/ seizures - Chronic fatigue - Nervousness/ anxiety - Edema/swelling - Are you pregnant? - Other symptoms (describe below)	- Head - Neck - Jaw/TMJ - Upper back - Middle back - Lower back - Sacrum - Tailbone - Pelvis - Rib cage - Shoulder blades - Right hand - Left hand - Right arm - Left hip - Right hip - Right knee - Left knee - Right foot - Left foot - Other locations (describe below)	- Emergency condition - Open wound or bleeding - Hypertonic crisis (BP>190/110) - Acute abdominal pain - Cardiac dysrhythmmia (>90<50) - Suspected vascular obliteration - Acute headache - Fever - Acute sensory impairment - Acute vaginal bleeding - Danger of fatal loss - Acute psychotic episodes - Acute danger of suicide - Aneurysms - Other concerns (describe below)

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Informed concern

I (your full name) _____ voluntarily give my informed consent to Osteopathic Manual Practitioner for the Osteopathic Care.

I acknowledge that the Osteopathic Manual Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing.

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 do not expect Osteopathic Manual Practitioners to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Osteopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Osteopathic Manual Practitioner may discuss my case with other healthcare providers. I consent to this file being shared with other Health Care Professionals if required. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

It is the responsibility of the patient to inform the practitioner of any pre-existing medical conditions, possible contraindications, any risks, injuries or disease of which patient are currently aware of. It is the right and responsibility to inform the practitioner of your condition, side effects during the session and, course of the treatment. The Osteopathic Manual Practitioner reserves the right to discontinue services where it is apparent that your expectations and the type of services provided are not compatible.

Treatments may include manual therapies where the health practitioner places the hands on the body. Many techniques will involve contact between patient`s body and the practitioner's body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones, inner thigh, gluteal area. If intraoral work is required (work inside the mouth), disposable latex or vinyl gloves will be worn. At times, the practitioner may ask the patient to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please inform immediately. The techniques can be discontinued or modified to be comfortable for you.

Your appointment has been reserved especially for you, however, if you need to cancel your appointment, out of respect for your therapist and your fellow patients, we ask that you provide the clinic with at least 48 hours advance notice. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. If you do not attend a scheduled appointment and do not call (text, email) to cancel or reschedule ("no show"), you will be charged 100% service fee.

I understand and agree that the health insurance policies are an arrangement between an insurance provider and myself. Furthermore, I understand that the health practitioner will prepare any necessary reports and forms to assist me in making collection form the insurance carrier. However, I understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment personally. I also understand that if I suspend my care or terminate my care at this office, any outstanding charges for professional services (including 100% fee for the current appointment) will be immediately due and payable.

I hereby declare that I was duly informed of current Manitoba Public Health orders, precautionary measures, including, but not limited to, recommendations related to the coronavirus pandemic. I further declare that I will abide by the above-mentioned rules while I am a patient at the Manual Osteopathy Rehabilitation Clinic and I assume the full responsibility for all the consequences (including, but not limited to, health issues) and outcomes caused by my actions or omissions.

Due to Manitoba Public Health orders of COVID-19 prevention, the Manual Osteopathy Manitoba Rehabilitation Clinic highly recommends you to follow the rules, helping to stay safe and prevent the spread of infection:

- If your traveled outside of Manitoba, please refrain from booking the appointment next 14 days after you have arrived
- Use the self-screening tool before booking and at the day of appointment https://sharedhealthmb.ca/covid19/screening-tool/
- If you are displaying fever, cough, the difficulty of breathing, sneezing or other unhealthy symptoms, cancel your appointment, stay home, ask for medical help
- Clients must maintain a distance of at least two metres, except when receiving service or for brief exchanges
- Follow waiting room management, which includes waiting in a car if possible, and physical distancing for those in a waiting room
- Sanitize your hands (hand sanitizer is available at the entrance/exit, wash your hands before and after the appointment)
- Patients may wear masks, protective equipment when receiving service if they prefer (bringing your own protective equipment are welcome). Patient can ask the therapist to wear the mask, gloves, protective equipment during the service

Date:_____ Signature:_____