Wellness for the Body
Massage Therapy & Healing Centre

Osteopathy

2418 Lakeshore Road West, Oakville, Ontario L6L 1H7
Phone: 905.465.4595 Web: www.wellnessforthebody.com

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Please consider giving us a daytime phone number, in the event we need to reach you the same day as your appointment.

Phone: (H)_____ (M)_____ (B)_____

Gender: □ Female □ Male Occupation: _____

Email: _____ Would you like to receive our monthly e-newsletter? □ Yes □ No

Where did you find our number? _____

If online, what site referred you? □ Google □ Facebook □ Instagram □ Twitter □ Other: _____

Health History

Chief complaint: _____

History of complaint: _____

_____

_____

Have you received osteopathic treatment before? □ No □ Yes If yes, when was your last treatment? _____

List other current therapies (i.e. chiropractic): _____

Doctor: _____ Phone: _____ City: _____

Current supplements/medications (conditions they treat): _____

_____

Surgeries/Injuries (Please list and date): _____

_____

Please list the presence and location of any internal pins, wires, artificial joints or special equipment: _____

_____

Motor Vehicle Accident? □ No □ Yes Date: _____

Other accident(s): _____ Date(s): _____

Family medical history: □ Cancer □ Diabetes □ Hi/lo blood pressure □ Heart disease □ Other _____

_____

Social history: □ Tobacco □ Coffee □ Marijuana □ Drugs □ Alcohol □ Other _____

please turn over...

Please check all applicable boxes (current or past conditions)

Cardiovascular:
- ○ High blood pressure
- ○ Low blood pressure
- ○ Chest pain
- ○ Chronic congestive heart failure
- ○ Heart disease
- ○ Myocardial infarction
- ○ Phlebitis
- ○ Cardio-vascular accident
- ○ Stroke
- ○ Pacemaker or similar device
- ○ Hypertension
- ○ Angina
- ○ Mitral Prolapse
- ○ Heart Palpitations
- ○ Varicose veins
- ○ Deep vein thrombosis
- ○ Blood clots
- ○ Poor circulation
- ○ Cold hands/feet
- ○ Lymphedema
- ○ Other _____

Skin:
- ○ Allergies (anaphylactic)
- ○ Rashes
- ○ Athletes foot
- ○ Warts
- ○ Cold sores
- ○ Eczema/psoriasis
- ○ Other (contagious) _____

Reproductive:
- ○ Pregnancy

(due date: _____)
- ○ Menstruation:

__ Absent __Painful
__ Heavy __Light
__ Normal __Irregular
- ○ Dysmenorrhea
- ○ Menopause:

__Pre __Active __Post
- ○ Other _____

Nervous System:
- ○ Herpes/shingles
- ○ Numbness/tingling
- ○ Loss of sensation
- ○ Chronic pain
- ○ Fatigue
- ○ Sleep disorder/insomnia
- ○ Chronic fatigue syndrome
- ○ Memory Loss

Other _____

Respiratory:
- ○ Chronic cough
- ○ Bronchitis
- ○ Shortness of breath
- ○ Asthma
- ○ Emphysema
- ○ Smoking
- ○ Pneumonia
- ○ Other _____

Musculo-skeletal:
- ○ Fibromyalgia
- ○ Bone or joint disease
- ○ Tendonitis
- ○ Bursitis
- ○ Fractures
- ○ Osteoarthritis
- ○ Rheumatoid arthritis
- ○ Sprains/strains
- ○ Swelling
- ○ Stiffness
- ○ Spasms/cramps
- ○ Pain (check area)

__Jaw/TMJ __Neck
__Shoulder __Elbow
__Wrist __Hip __Knee
__Ankle __Low back
__Upper back __Mid Back

Digestive:
- ○ Poor digestion
- ○ Constipation
- ○ Gas/bloating
- ○ Nausea/vomiting
- ○ Diarrhea
- ○ Ulcer
- ○ Irritable bowel syndrome
- ○ Liver/gall bladder
- ○ Kidney/bladder issues
- ○ Kidney/gall stones
- ○ Other _____

Infectious Diseases:
- ○ Hepatitis
- ○ Tuberculosis
- ○ HIV
- ○ Venereal Disease
- ○ Herpes
- ○ Dermatitis
- ○ Other _____

Other:
- ○ Diabetes
- ○ Anemia
- ○ Dizziness
- ○ Vertigo
- ○ Earaches
- ○ Ringing in ears
- ○ Sinus problems
- ○ Loss of smell/taste
- ○ Vision/hearing loss
- ○ Thyroid issues
- ○ Hormone imbalance
- ○ Cancer
- ○ Epilepsy
- ○ Anxiety/depression
- ○ Panic Attacks
- ○ Headaches/migraines

How often: _____
- ○ Allergies:

__Food __Drug
__Environmental
- ○ Other _____

Client Consent Statement

In keeping with the Health Care Consent Act (1996), it is my choice to receive therapy. I understand that an assessment by a therapist is required to determine the best course of treatment. I am aware that all information provided is private and confidential and will not be released without my written consent. I agree to communicate with my therapist at any time if I have any questions, if I feel uncomfortable, or I feel that my wellbeing is being compromised. I will consent to the therapist working only on those areas of my body that I am comfortable with. I understand and am aware of the posted fees and cancellation policy. I am also aware of the possible side effects from a treatment such as temporary muscular discomfort (24-48hrs post treatment) and possible dizziness. I understand the therapist will recommend remedial exercises and home care.

Cancellation & Fee Policy

For a full detailed price list: www.wellnessforthebody.com

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, there is a charge of $45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the full regular fee.

Payment is due at the time services are rendered. This policy applies to all our patients. Patients with extended health care coverage should note, our office does not file claims on your behalf, nor bill your insurance company directly.

I understand and am aware of the Cancellation & Fee Policy. I also agree that if I am late for my appointment, I will receive the remainder of the appointment time and will be responsible for the full payment of the scheduled appointment.

Signature: _____ Date: _____

_____

_____

_____