# PATIENT/CLIENT INTAKE FORM

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Last Name:_____ Name: _____ Gender: M __ F __Date Of Birth: _____
(Mm/Dd/Yyyy)

**For Office Use Only**
Driver's License Number: _____ Photo Id: Y ___N___

Address:_____ Apt: _____ City: _____
Postal Code: _____ Home Phone: _____Bus: _____
Cell: _____ Email: _____ Occupation: _____
Who May We Thank For Referring You To Our Care? _____
name of family member, friend, co-worker, internet, yellow pages, street sign etc.

Are You Currently Seeing A Health Professional For Your Condition? Yes/No,
Please Explain: _____
Doctor's Name: _____
Doctors Address: _____
Last Visit: _____

| **Health History:** | | | |
|---|---|---|---|
| ☐ Heart Palpitations | ☐ Pacemaker | ☐ Bruise Easily | ☐ Sinus Problem |
| ☐ Heart Murmur | ☐ Artificial Valves | ☐ Aids/Hiv | ☐ Thyroid Disease |
| ☐ Arteriosclerosis | ☐ Artificial Joints | ☐ Heart Attack | ☐ Allergies |
| ☐ Stroke | ☐ Recent Fractures | ☐ Trouble Hearing | ☐ Angina Pectoris |
| ☐ High Blood Pressure | ☐ Broken Bones | ☐ Shortness Of Breath | ☐ Other: |
| ☐ Low Blood Pressure | ☐ Asthma | ☐ Hepatitis | |
| ☐ Cortisone/Steroid Therapy | ☐ Inflammatory Rheumatism | ☐ Recent Appetite Change | |
| ☐ Liver Disease | ☐ Epilepsy | ☐ Pregnant | |
| ☐ Diabetes | ☐ Congenital Heart Cond. | ☐ Blood Disorders | |

I agree to inform my practitioner of any concerns/changes to the status of my condition(s).

I understand that InsideOut Wellness Centre can provide courtesy notification for my appointments via text, e-mail or telephone. It is my responsibility to note the time and date of all my appointments. I understand that a minimum of 24 hours notice is required to change or cancel my appointment.
I understand that fees charged are due when the service is rendered.

I understand that the information that I give on this form will be strictly confidential and will be kept very private in accordance with The Registered Health Practitioners Act and Privacy Legislation.

Practitioners/Therapist Name: _____

Patient/Guardian Signature: _____Date: _____

**Most services are covered by Extended Health Insurance. Please check with your benefits administrator at work.**

**45-3560 Rutherford Road, Woodbridge, ONT. L4H 3T8 Tel. 905-303-462**

## INFORMED CONSENT TO OSTEOPATHIC TREATMENT

I understand that my Osteopathic Therapist is providing osteopathic therapy services within his/her scope of practice.

I hereby consent to my Osteopathic Therapist to treat me with Osteopathic manual therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Therapist.

I acknowledge that an Osteopathic Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic 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 acknowledge and understand that the Osteopathic Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Therapist and have disclosed to the Osteopathic Therapist all of those medical conditions affecting me. It is my responsibility to keep the Osteopathic Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize _____my Osteopathic Therapist to release or obtain information pertaining to my conditions(s) and/or treatment to/from my other caregivers or third party practitioners.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Therapist from time to time, to deal with my physical conditions and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Client Signature: _____

Date: _____