Tracey Clark
Osteopathic Manual Practitioner

integration therapeutics

Osteopathic Adult Intake

General Information

Please complete the following information in full. Thank you.

Dr. Miss Mr. Mrs. Ms

Name: (last, first, middle initial)_____

Date of Birth:___/___/_____! Age:_____ Gender: M / F

Address:_____

Town/City:_____Province:_____Postal Code:_____

Telephone: Home:_____Work:_____Cell:_____

Email:_____

Occupation:_____

Marital Status:_____Number of children:_____

Emergency Contact

Name:_____Relationship:_____Telephone:_____

Primary Physician

Name:_____Telephone:_____

Other health care practitioners that you are seeing:

1._____

2._____

3._____

How did you hear about our clinic? Referral Advertisement Friend/Family Sign Newsletter

Referred by:_____

Health and Lifestyle Information

What is your main health concern?

_____

_____

_____

Please list any other health concerns in order of importance (physical, emotional, mental):

1._____

2._____

3._____

Please list any dietary restrictions:_____

_____

How much water do you drink per day?_____

How many and what type of alcoholic beverages do you have per week?_____

_____

Do you smoke? Y / N How many cigarettes daily?_____

Have you ever smoked? Y/N When did you quit?_____

On average how many hours do you sleep a night?_____

Do you have trouble falling asleep? Y / N

Do you wake up during the night? Y / N Any specific time?_____

Do you exercise regularly? Y / N

What type of exercise and how often?_____

_____

_____

How do you rate your overall health? Poor 1--2--3--4--5--6--7--8--9--10 Excellent

How do you rate your overall energy level? Poor 1--2--3--4--5--6--7--8--9--10 Excellent

How do you rate your stress level? Low 1--2--3--4--5--6--7--8--9--10 High

Which factors contribute to your stress? (please circle)

Health Work Family Marriage Other:_____

Medications and Supplements

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/Day	How long?

Please list all current vitamins/minerals, herbs or homeopathic remedies, the daily dose and how long you have taken it.

Supplement	Dose/Day	How long?

How many courses of anti-biotics have you had in the last 10 years?_____

Have you had a bad reaction to any medication? Y / N

Medical History

Please briefly describe your dental history (root canals, fillings, extractions, etc.)

_____

_____

_____

Do you grind or clench your teeth at night? Y / N Do you wear a splint? Y / N

Do you have any pain or discomfort in your jaw? Y / N

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations:

_____

_____

_____

Have you had any Motor Vehicle Accidents? Y / N

If yes, please explain (approximate date, nature of accident, injuries):_____

_____

_____

_____

_____

Please indicate if you have had any of the following childhood illnesses (please circle):

Asthma	Measles	Rheumatic fever	
Eczema	Mumps	Scarlet fever	
Frequent ear infections or colds	Rubella (German measles)	Whooping cough	
Chickenpox	Polio	Other:_____	Immunizations (please circle):
DPT	Hemophilus Influenza B	Hepatitis A	Hepatitis B
Flu shot	Tetanus Booster	MMR	Polio
Smallpox	Chicken Pox	Other:_____	

Family History

Please indicate whether any of your family members have, or have had any of the following (indicate which relative):

Cancer (which type?)	_____	Diabetes	_____	Heart disease	_____
High Blood pressure	_____	Stroke	_____	Glaucoma	_____
Alcoholism	_____	Kidney disease	_____	Thyroid disease	_____
Epilepsy	_____	Mental Illness	_____	Asthma	_____
Allergies	_____	Anemia	_____	Other_____	

Women's Health

Are you currently pregnant? Y / N

Is your period regular? Y / N Is your period painful? Y / N

Do you experience low back pain? Y / N Any other symptoms? _____

Length of monthly cycle (days): _____ Average length of period and flow (days): _____

Do you get regular Pap smears? Y / N Date of last Pap smear: _____

Are you menopausal? Y / N If yes, date of last period:_____

Current forms of contraception? _____

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

Number of pregnancies? _____Births? _____Miscarriages? _____Abortions? _____

Men's Health

Do you have regular screening tests done (blood work, prostate examination)? Y / N

Date of last prostate examination? _____

Do you have difficulty urinating completely? Y / N

How many times do you get up from your sleep to go to the bathroom at night? _____

Review of Systems

Please circle if you are currently experiencing any of the following or write P if you experienced it in the past.

General Symptoms
Headache
Head Injury
Concussion
Fever
Chills Sweats
Dizziness
Fainting
Loss of sleep
Fatigue
Nervousness
Weight Loss
Numbness in extremities
Allergy
Convulsions

Skin
Hives or allergy
Acne or skin eruptions
Itching
Dryness
Boils
Sensitivity
Easy Bruising
Varicose Veins

Kidneys & Reproduction
Urinary Incontinence
Frequent urination
Painful urination
Blood in urine
Kidney Infections
Bladder Infections
Prostate trouble
Sores on genitals

Eyes, ears, Nose, Throat
Gum trouble
Frequent colds
Enlarged Thyroid
Tonsillitis
Sore throat
Hoarseness
Enlarged glands
Glaucoma
Failing vision
Eye pain
Deafness
Ear ache
Nasal drainage
Nasal obstruction
Sinus infection
Hay fever
Mercury tooth fillings

Cardio-Vascular
Low blood pressure
High blood pressure
Hardening of the arteries
Swelling in the ankles
Poor circulation
Irregular heart beat
Shortness of breath
Chest pain

Gastro-Intestinal
Excessive thirst
Excessive hunger
Belching
Gas (flatulence)
Bloating
Nausea Vomiting
Abdominal cramps
Constipation
Diarrhea
Hemorrhoids (piles)
Liver problems
Gallbladder problems
Jaundice
Colitis

Respiratory
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Difficulty breathing

Musculo-Skeletal
Muscle Stiffness
Muscle weakness
Back pain
Swollen joints
Painful tailbone
Herniated discs
Bulging discs
Arthritis
Fractures
Dislocations
Strains/Sprains

What are your treatment goals and expectations? _____
_____
_____

Is there anything else that you feel has not been covered? _____
_____
_____

Thank you very much for taking the time to complete this form

Informed Consent to Osteopathic Treatment

Osteopathic manual therapy is the treatment and prevention of disease by natural means. Osteopathic manual therapists assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. A variety of techniques, including soft-tissue, skeletal, and cranio-sacral techniques are used in order to stimulate the body's inherent healing capacity. Your osteopathic manual therapist will take a thorough case history and perform a complete physical examination.

It is very important that you inform your osteopathic manual therapist of any condition or disease that you currently have and if you are on any medication or over-the-counter drugs. If you are pregnant, or suspect you are pregnant please advise your osteopathic manual therapist.

There are some slight health risks to treatment by an osteopathic manual therapist. These include but are not limited to: aggravation of the pre-existing symptoms; evocation of other symptoms; and pain and bruising from performed musculo-skeletal techniques.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or law requires it. I understand that I may look at my medical records at any time and can request a copy of it by paying the appropriate fee.

I understand there is a cancellation policy. If I cancel my appointment less than 24 hours in advance then I understand I will be charged the full cost of the visit.

I understand that the results are not guaranteed. I do not expect the osteopathic manual therapist to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for:

_____

Dated this _____day of _____, 20___

_____ _____

Patient / Guardian Signature Witness Signature

_____ _____

Patient Name (please print) Witness Name (please print)

Fee Schedule:

Initial Assessment and Treatment: $125

45 minute follow-up: $100

30 minute follow-up: $60

Package Pricing: $300 (initial assessment, one 45 minute follow up, two 30 minute follow up sessions)