

Patient Information

Personal Information

First Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Last Name: _____ Address: _____

Telephone Home: (_____) _____ City & Province: _____

Telephone Cell: (_____) _____ Postal Code: _____

Telephone Work: (_____) _____ ext. _____ Preferred Pronouns: HE SHE THEY Other: _____

Email: _____ Preferred name (nickname/short form): _____

Reason for today's visit: _____

Emergency Contact Name: _____

Emergency Contact Number: (_____) _____

Work

Employer: _____

Occupation: _____

Number of years at this type of work: _____

Type of work (physical, repetitive movement, computer): _____

Sport

Sports / Activities: _____

Number of years in this sport/activity: _____

Level of competition (rec/club/national/pro): _____

Referral

How did you hear of our clinic?

- ☐ From your physician
- ☐ From another patient (specify): _____
- ☐ Other: _____

(Please provide as much detail as possible)

Physician

Family physician's name: _____

Phone number and address:
(Leave blank if unknown)

Date of last physical checkup: _____

Have you consulted our clinic in the past? Yes / No

Please read and sign

Our clinic requires at least 24 hours notice for all cancellations and rescheduling.

*** Cancellations within 24 hours of your appointment will be subject to a cancellation fee (50% of the regular appointment fee)**

*** Additionally, it is your responsibility as a patient to verify your insurance coverage amounts and exclusions where they exist.**

We greatly appreciate your respect and cooperation in managing the schedule. Please arrive 5-10 minutes before your appointment time and wear appropriate clothing. Thank you.

Signature: _____

Date: _____



Health History

How would you describe your **general health**? _____

Have you previously been treated in Osteopathy, Athletic Therapy, Physiotherapy, or Massage Therapy? (Please circle all that apply)

Are you currently in treatment with another healthcare practitioner? Yes / No

If so, for what condition(s)? _____

Are you currently taking any **medications** (including aspirin, ibuprofen, etc)? Yes / No

If so, which medications/condition(s)? _____

Have you had any **surgeries** or **injuries** we should be aware of? Yes / No

If so, please elaborate (including date, treatment received, etc) _____

Please put a checkmark beside any conditions you are experiencing or have experienced in the past:

Cardiovascular:

- ___ High blood pressure
- ___ Low blood pressure
- ___ Chronic congestive heart failure
- ___ Heart disease / heart attack
- ___ History of stroke / TIA's
- ___ Phlebitis / varicose veins
- ___ Pacemaker or similar device
- ___ Poor circulation / loss of sensation
- ___ Dizziness

Respiratory:

- ___ Shortness of breath
- ___ Asthma
- ___ Bronchitis
- ___ Emphysema
- ___ Sinus infections
- ___ Chronic cough
- ___ Seasonal allergies

General:

- ___ Pre-Diabetes / Diabetes
- ___ Epilepsy
- ___ Cancer
- ___ Arthritis
- ___ Digestive issues
- ___ Allergies (anaphylaxis)
- ___ Food sensitivities
- ___ Stress / anxiety
- ___ Open cuts / sores
- ___ Bruise easily

Infections:

- ___ Infectious skin conditions
- ___ Infectious respiratory conditions
- ___ Tuberculosis
- ___ Hepatitis
- ___ Herpes
- ___ HIV

Head/Neck:

- ___ Concussion / head trauma
- ___ Tension headaches
- ___ Migraine headaches
- ___ Fatigue
- ___ Insomnia
- ___ Whiplash
- ___ Jaw pain / TMJ issues
- ___ Vision impairments
- ___ Hearing loss

Musculoskeletal:

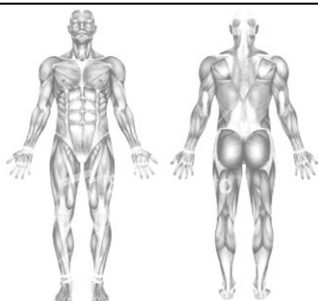
- ___ Bone or joint disease
- ___ Tendonitis / bursitis
- ___ Fractured bones
- ___ Sprains / strains
- ___ Fibromyalgia
- ___ Sciatica
- ___ Scoliosis

Other medical conditions (e.g. pregnancies, hemophilia, osteoporosis, gynecological conditions, mental illness,) **or special notes** (presence of internal pins, wires, artificial joints, special equipment, etc.) :

Pelvic:

- ___ Constipation
- ___ Abdominal / pelvic pain
- ___ Ovarian cysts
- ___ Uterine fibroids
- ___ Endometriosis / PCOS

Using the diagram,
please circle any areas
in which you are
currently experiencing
pain, stiffness, numbness
or other symptoms.



**I certify that all the above information is
accurate and up-to-date.**

Signature:

Date:

Clinic Use Only

Updated Initials Updated Initials Updated Initials



Privacy Policy Consent Form

Privacy of your personal information is important to Ottawa Osteopathy & Sports Therapy. We are committed to collecting, using, and disclosing your personal information responsibly. Our privacy policy ensures that:

- Your information is kept private (unless required by law);
- We have obtained your consent before sharing your information with other healthcare professionals;
- Only necessary information is collected about you;
- Storage, retention, and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- All of our privacy protocols comply with privacy legislation: the Personal Health Information Protection Act (PHIPA); and standards of our regulatory bodies: the Canadian Athletic Therapists Association (CATA), Ontario Association of Osteopathic Manual Practitioners (OAO), College of Massage Therapists of Ontario (CMTO), and the College of Physiotherapists of Ontario (CPO).

Use and Disclosure of Personal Information

The clinic will only collect, use, and disclose information about you for the following purposes:

- To assess your health concerns, provide health care, and advise you of treatment options
- To establish and maintain contact with you, and remind you of upcoming appointments
- To send you newsletters, educational materials, and other information mailings
- To allow us to efficiently follow-up for treatment, care and billing
- To communicate with other treating healthcare providers
- To complete or verify claims for insurance purposes
- To comply with legal and regulatory requirements

Statement of Consent

I have reviewed the privacy policy used by Ottawa Osteopathy & Sports Therapy.
I agree that I am giving my informed consent to the collection, use and/or disclosure of my personal information as outlined above, and that I may withdraw this consent at any time.

Patient's Signature *(or parent/guardian, if patient is under 16)*

Date