



Patient Information

Personal Information	
First Name:	Date of Birth: D M Y / / 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? <input type="checkbox"/> From your physician <input type="checkbox"/> From another patient (specify): <input type="checkbox"/> Other: _____ <i>(Please provide as much detail as possible)</i>	Physician Family physician's name: Phone number and address: <i>(Leave blank if unknown)</i> 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:

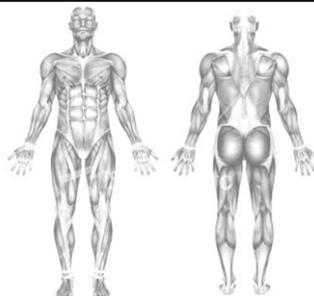
- Bone or joint disease
- Tendonitis / bursitis
- Fractured bones
- Sprains / strains
- Fibromyalgia
- Sciatica
- Scoliosis

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



COVID-19 Waiver for In-Clinic Appointments

I, (print name) _____ understand the novel coronavirus (COVID-19) has an incubation period that can last up to 14 days, and that some asymptomatic carriers of the virus may still be contagious during this time.

I confirm that if I attend an in-clinic appointment with a health care practitioner (HCP) at Ottawa Osteopathy and Sports Therapy (OOST) I am expressly accepting the risks associated with entering OOST and being closer than the recommended social distancing guidelines (2 meters/6 feet), including physical contact, with the HCP and/or OOST staff, during the COVID-19 pandemic.

By signing below, I voluntarily agree to release OOST, HCP, all staff, directors, officers and/or owners from any and all claims of personal injury and/or damages related to this appointment and/or COVID-19, now and/or at any point in time in the future.

We care a lot about your health and follow strict regulatory guidelines to keep everyone safe. Visit www.ottawaosteopath.com to read about our COVID-19 In-Clinic Procedures.

Signed in Ottawa, Ontario.

Date: _____ Patient Signature: _____