

OSTEOPATHY NARELLAN

PROUD MEMBERS OF THE AUSTRALIAN OSTEOPATHIC ASSOCIATION

This extensive questionnaire is an important first step in helping to understand and treat your health concern. Please assist by completing the form as fully as possible. All information is held in the strictest of confidence.

Date: ____ / ____ / ____

Name: _____	Date of Birth: ____ / ____ / ____
Address: _____ _____	Employers Name: _____
Post Code _____	Employers Address: _____ _____
Contact Information	
Mobile: _____	Home: _____
Work: _____	Email: _____

Release of Client Information: On occasions your treating Osteopath _____ maybe in communication with a third party about your condition, treatment and management. This third party may include but not limited to your General Practitioner, Workers Compensation Insurance Agency, Motor Vehicle Third Party Insurer or Employer. Your Osteopath _____ will only be in communication with the above agencies if it is reasonable and necessary. You will be informed should this be the case.

<u>Main Purpose of Visit:</u> _____ _____	Are you under treatment for any health condition at present? _____ _____
Referred By: _____	Please list current medications: _____ _____ _____
Doctors' Name: _____	Have you had any surgery, or hospitalization? _____ _____
Doctors' Address: _____ _____	Do you smoke? How many per day? _____
Private Health Insurer: _____	Do you drink alcohol? How much per day? _____
Occupation/Duties: _____	Claim No: _____
If applicable:- WorkCover or Third Party Insurance Company: _____	

SALLY WATSON & ASSOCIATES

5 DONCASTER AVENUE NARELLAN NSW 2567
T 02 4647 6700 F 02 4648 4515

E INFO@OSTEOPATHYNARELLAN.COM.AU

W WWW.OSTEOPATHYNARELLAN.COM.AU

Do you suffer from any of these conditions?			Is there Family History of any of these conditions?
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Migraines	<input type="checkbox"/> Nausea/Reflux	<input type="checkbox"/> Obesity
<input type="checkbox"/> Blood Pressure Irregularities	<input type="checkbox"/> Stroke/Blackout	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Slow Digestion	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Thrombosis/Clots	<input type="checkbox"/> Photophobia	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint Stiffness/Swelling	<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Strokes
<input type="checkbox"/> Cancer	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Breathlessness	<input type="checkbox"/> Cancer
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Persistent Cough	
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Asthma/Bronchitis	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Recent Infections	

For Women:	For Men:
<input type="checkbox"/> Menstrual Pain <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Menopause <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Breast Pain	<input type="checkbox"/> Prostate Conditions <input type="checkbox"/> Incontinent <input type="checkbox"/> Urinary Difficulties
No: of Children _____ No: of Pregnancies _____ Complications during Pregnancy / Labour - _____ _____	

CONSENT TO OSTEOPATHIC TREATMENT

OSTEOPATHIC CARE IS RECOGNISED AS BEING AN EFFECTIVE AND SAFE METHOD OF CARE FOR MANY CONDITONS. HOWEVER, YOU MUST RECOGNISE THAT THERE ARE RISKS ASSOCIATED WITH ALL HEALTH CARE PROCEDURES WHICH YOU SHOULD BE INFORMED ABOUT.

PLEASE READ THE FOLLOWING CAREFULLY:

- I acknowledge that I have discussed with _____ the rare risks associated with my proposed care which include although are not limited to muscle and joint soreness, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition.
- I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

- I have had the opportunity to discuss the proposed care with _____. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed osteopathic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
- I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
- I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
- I hereby acknowledge my consent to the performance of the proposed osteopathic care by _____ and/or any other osteopath working in this clinic. I understand that I can withdraw consent at any time.

CANCELLATION/MISSED APPOINTMENT CHARGES

As part of our clinics services, you will be informed of your appointment, by either SMS or phone call, the day prior. If you can not attend we ask that you contact us the day prior to make alternative arrangements. If you cancel within 24hrs of your designated appointment, a cancellation fee of \$40.00 will be invoiced. This will be invoiced at the discretion of the clinic. Exemptions will be allowed for unforeseen circumstances.

Patient's Signature: _____
(Patient or Guardian to also sign if patient is under 18rys of age)

Patient's Name: _____ Dated: ____/____/____
(Printed)