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: _____

Address:

_____

_____

Post Code _____

Date of Birth:_____/_____/_____

Employers Name:

_____

Employers Address:

_____

_____

Contact Information

Mobile: _____

Work: _____

Home: _____

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.

Main Purpose of Visit:

_____

_____

Referred By:_____

Doctors' Name: _____

Doctors' Address:

_____

_____

Private Health Insurer:_____

Occupation/Duties:

_____

If applicable:- WorkCover or Third Party Insurance Company:

_____

Claim No:_____

Are you under treatment for any health condition at present?

_____

_____

_____

Please list current medications:

_____

_____

_____

_____

Have you had any surgery, or hospitalisation?

_____

_____

_____

_____

Do you smoke? How many per day?

_____

Do you drink alcohol? How much per day?

_____

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

For Women:		**For Men:**
☐ Menstrual Pain	No: of Children _____	☐ Prostate Conditions
☐ Irregular Cycle	No: of Pregnancies _____	☐ Incontinent
☐ Menopause	Complications during Pregnancy / Labour -	☐ Urinary Difficulties
☐ Breast Lumps	_____	
☐ Breast Pain	_____	

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:

1. 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.
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

   _____
3. 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.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. 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 unforseen circumstances.

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

Patient's Name: _____ Practitioner Name: _____

Dated:__ / ____ / ____ Dated:____ / ____ / ____