RIVER STONE

OSTEOPATHY

Confidential Patient Case History Form

Date _____

Name: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Birthdate: (Day)_____ (Month)_____ (Year)_____

Occupation: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

How did you hear about us? (check one below)

❒ Google ❒ Facebook ❒ Instagram ❒ Storefront Sign ❒ River Stone Therapist: _____

❒ World Weight Loss Inc. ❒ Doctor or lawyer: _____ ❒ Other: _____

I agree that River Stone Massage may notify me of new treatments and promotions via email. ❒ Yes ❒ No

Primary reason for visit: _____

When did this begin? _____

How did this occur? _____

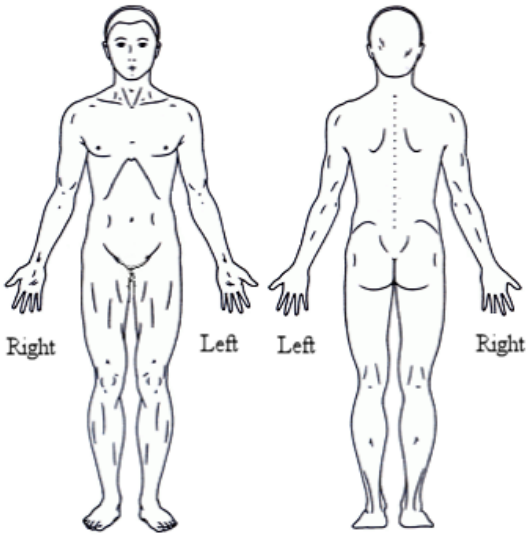
Since it began has the condition: ❒ Improved ❒ Worsened ❒ Unchanged

What have you done for this condition? _____

Describe your general health: _____

Mark on the body diagram:

◯ Circle areas of pain
///// Lines through areas of tingling/numbness



Using the scale, indicate the severity of the pain you are experiencing now by circling a number:

Little/no pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Have you ever been involved in a motor vehicle accident? ❒ Yes ❒ No Date:_____

Have you had a hard fall onto your back or buttocks? ❒ Yes ❒ No Date:_____

Have you ever been knocked unconscious? ❒ Yes ❒ No Date:_____

Have you ever had a hard blow to the head or a concussion? ❒ Yes ❒ No Date:_____

Have you ever been pregnant? ❒ Yes ❒ No

Are you pregnant now? ❒ Yes ❒ No

Number of times given birth? _____ **Number of C-sections?** _____

Are you presently taking any prescribed medication(s)? ❒ Yes ❒ No

If yes, please record the medication(s) and the condition(s) for which it is being used if known.

_____

_____

_____

Do you at the present time experience:

❒ Yes ❒ No Dizziness, weakness, fainting, vertigo, drop attacks or disorientation?

❒ Yes ❒ No Disturbances of vision, speech co-ordination or balance, or difficulty swallowing?

❒ Yes ❒ No Numbness or pins and needles in any part of your body?
Where? _____

❒ Yes ❒ No Difficulty with bowel or bladder function?

❒ Yes ❒ No Cough, shortness of breath, chest pain, or palpitations?

❒ Yes ❒ No Poor appetite, nausea or vomiting?

❒ Yes ❒ No Difficulty Sleeping?

❒ Yes ❒ No A significant weight change in the past year?

Have you ever experienced:

❒ Yes ❒ No Recurrent ear, throat or sinus infection?

❒ Yes ❒ No Respiratory disease or disorders? (i.e. asthma, pneumonia etc.)

❒ Yes ❒ No Stomach, intestinal or any digestive problems?

❒ Yes ❒ No Bladder or kidney problems? (i.e. infection, kidney stones, etc.)

❒ Yes ❒ No Gynecological conditions? (i.e. endometriosis, cysts, fibroids, etc)

❒ Yes ❒ No Have you ever consulted a physician for any of the above?

If yes, please explain: _____

_____

Do you have any of the following conditions?

❒ Diabetes
❒ Cancer
❒ Allergies _____
❒ Heart disease/problems
❒ Arthritis (type: _____)
❒ High/Low blood pressure
❒ Stroke/CVA
❒ Epilepsy (type: _____)
❒ Asthma
❒ Skin conditions
❒ Hepatitis
❒ HIV/AIDS
❒ STD
❒ Tuberculosis

<u>Family History:</u>

Please identify any problems listed above that have occurred in your immediate family (indicate family members affected)

Ailment:	Family member:
_____	_____
_____	_____
_____	_____

Special Considerations (circle those that apply):

Pacemaker Rods/Pins/Wires Artificial Joints Medication Patch

Other: _____

I acknowledge that a Manual Osteopath is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that Manual Osteopathy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge and understand that the Manual Osteopath must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Manual Osteopath and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Manual Osteopath updated on my medical history. I give consent for my treatment notes to be read by the other health care professionals at River Stone Wellness Centre. The information I have provided is true and complete to the best of my knowledge.

For insured clients:
I hereby consent to direct billing so that River Stone Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

Cancellation Policy:
We require 24 hours' notice if you need to cancel or change your appointment so that we may accommodate another client in need of therapeutic services. If you cancel with less than 24 hours' notice or forgo your appointment, a $50.00 fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server.

I have read and understand the Cancellation Policy: _____ (Client Initials)

_____ _____ _____

Client Signature Date Therapist Signature