

Date: _____

o Irritable bowel syndrome

o Liver/gall bladder

o Kidney/bladder

o Tuberculosis

o HIV



Osteopathy Patient Intake Form

Name:		Date of Birth: DD/MM/YY	//
Address:		City:	Postal code:
Phone #: (Business)	(Home)	(Cell) _	
Email:			
	# Cell# Home# I		
		Referred by:	
Health History		_ 110101100 0 j	
		Address:	
Surgeries (Please list and date			
Please list the presence and l	ocation of any internal pins, wi	res, artificial joints of special equ	ipment:
Motor Vehicle Accidents? Y	YES NO		
Date:	Site of Injury:		
Other Accidents/Traumas? Y	YES NO		
Date:	Site of Injury:		
	ble boxes below (past and cur	rent):	
<u>Cardiovascular</u>	<u>Musculoskeletal</u>	<u>Skin</u>	Nervous System
 High blood pressure 	 Bone or joint disease 	 Allergies (anaphylactic) 	Herpes/shingles
 Low blood pressure 	 Tendonitis 	Rashes	 Numbness/tingling
 Heart disease 	 Bursitis 	 Athletes foot 	 Chronic pain
 Myocardial infarction 	Fractures	o Warts	o Fatigue
o Phlebitis	 Osteoarthritis 	 Eczema/psoriasis 	 Sleep disorder
 Cardio-vascular accident 	 Rheumatoid arthritis 	Other (contagious)	 Loss of sensation
o Stroke	 Sprains/strains 	.	
o Pacemaker	o Swelling	Respiratory	Other
 Varicose veins 	o Stiffness	o Chronic cough	O Drug/alcohol addiction
o Blood clots	 Spasms/cramps 	o Bronchitis	o Nicotine/caffeine addiction
o Osteoarthritis	o Pain (check area)	 Shortness of breath 	o Diabetes
 Lymph edema 	JawNeckShoulder	o Asthma	o Vision/hearing loss
Digestive	ElbowWristHip	Emphysema	o Headaches/migraines
o Constipation	KneeAnkleBack	o Smoking	o Cancer
o Gas/bloating			o Epilepsy
o Nausea/vomiting	Infectious Diseases	Reproductive	o Allergies (please list)
Irritable bowel syndrome	o Hepatitis	Pregnancy (trimester)	5 1 morgans (prouse mar)

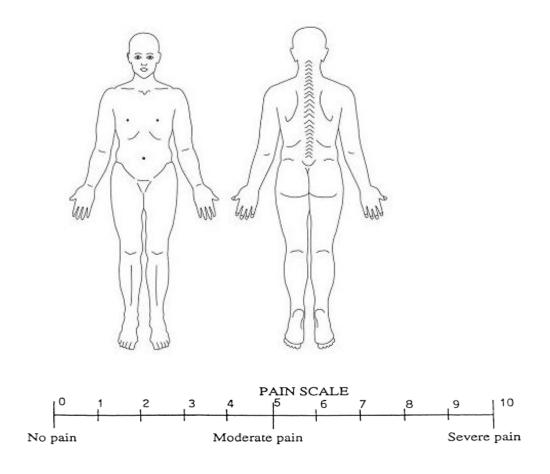
o PMS





INDICATE AREAS OF PAIN OR DISCOMFORT

X = Pain O = Numbness Z = Tingling S = Stiffness Other = _____



Intake Form Consent:

I understand and acknowledge that the information requested on page one and two is up to date and the purpose is to assist the Osteopathic Manual Practitioner in treating patient safely. Please note that all information provided below will be kept confidentially unless allowed or required by law.

Patient Printed Name	Signature of Patient / Guardian	
Date Signed		