the health centre

Candace Kakowchyk, Manual Osteopathy

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____

_____ **Marital status**

_____ | S | M | W | D | SEP |

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Length of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mammogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

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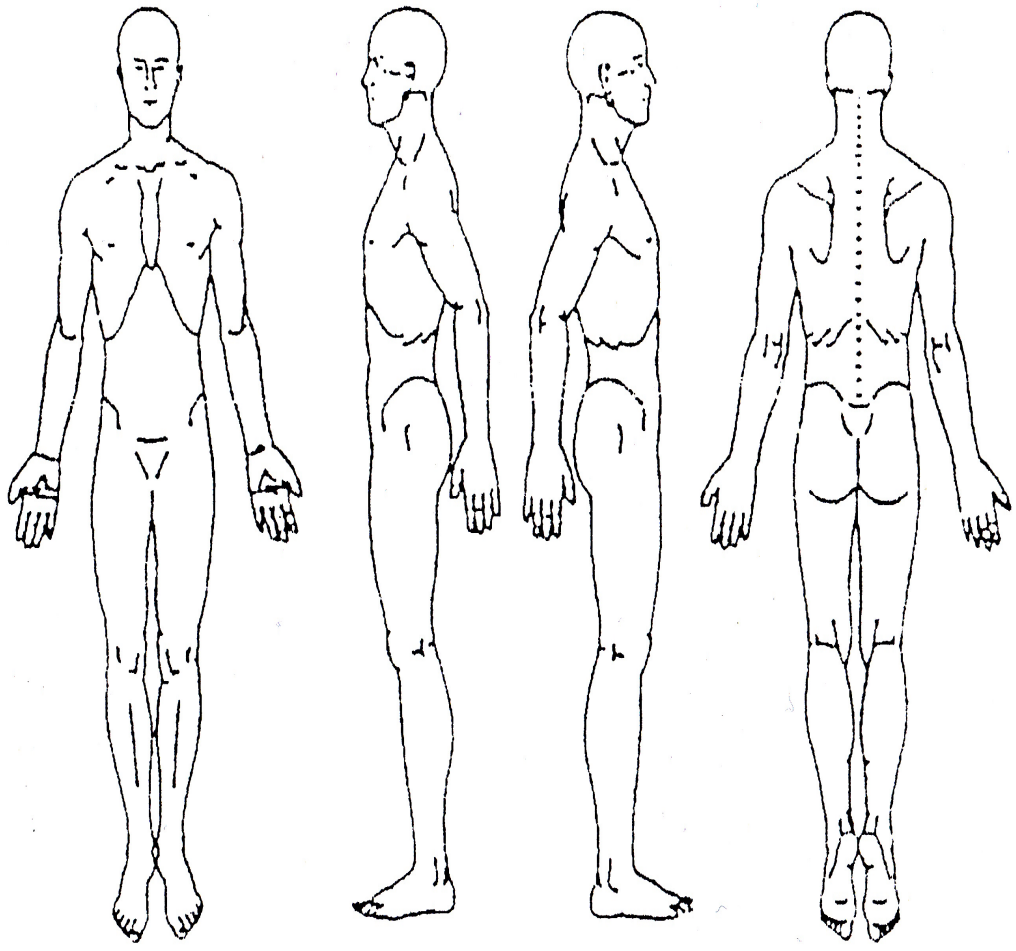
How can I help you today? Why are you seeking manual Osteopathy?

_____

_____

Have you received osteopathic treatment before? Please Circle one: **Yes** **No**

Please Indicate the TYPE and LOCATION of symptom you are feeling in the appropriate area, using the indicators in the box to the right: (Feel free to overlap, and use multiple indicators)



N = Numbness

T = Tingling

S = Sharp

A = Achy

D = Dull

Th = Throbbing

Bu = Burning

St = Stiffness

Cr = Cramping

Sw = Swelling

Sh = Shooting

When did your symptoms start? When was the onset of these symptoms?
Please circle the best estimate:

Days ago **Weeks Ago** **Months ago** **Years ago** **Unsure**

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Is there a known cause for your symptoms? Do you know how they were brought on?

_____

_____

What is the frequency of your symptoms? How often do they happen?

_____

_____

Please indicate the approximate intensity of your symptoms out of 10:

("1", meaning none "5" meaning moderate and "10" meaning the worst.)

At its best: /10 At its worst: /10 Now: /10

When you experience your symptoms, how long do they last? (days, hours, minutes, seconds?):

_____

_____

Is there any time of the day that your symptoms are worse? Please circle one:

Morning Afternoon Night-time (disturbs sleep: Yes or No)

What seems to aggravate your symptoms? Please also include any daily activities that are more difficult because of your condition:

_____

_____

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What seems to alleviate your symptoms? (heat, ice, rest, stretching etc):

_____

_____

Primary Health Care Provider name and phone number:

_____

_____

Have you received a diagnosis from your Doctor for a condition? Please circle one:

Yes No If yes, please describe, to the best of your knowledge what the diagnosis is, and indicate, approximately when you were diagnosed:

_____

_____

Please list any surgeries you have had:

_____

_____

Were you **hospitalized** for any injury/condition? Please circle one: Yes No
If yes, what was the hospitalization for? (Please also include the approximate date)

_____

_____

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Please indicate below, any history of injury:

_____

_____

Please indicate any hobbies or exercise interests, for us to understand your activity level:

_____

_____

Are you receiving any treatment from any other health-care professionals? Please circle one and/or write below:

Chiropractor

Naturopathic Doctor

Massage Therapist

Physiotherapist

Acupuncturist

Chinese Medicine

Other:_____

Is your current treatment helping? Please Circle one: Yes No

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Email:

_____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as the IV Wellness Boutique Inc. specials and newsletters.

Referred by:

_____

What to wear to your appointment:

Please wear loose fitting clothes, such as shorts or sweat pants, and a shirt with no collar or a tank top. Sessions require access to the upper back/neck; therefore restrictive clothing can limit the session.

Through scheduling an appointment, I understand that I am responsible to show up at that time. If I fail to cancel 24 hours before or show up late or fail to arrive to my appointment, I understand the entire treatment fee will be my responsibility. I also understand that it is ultimately my responsibility to advocate for my own safety, and desires during the treatment, and I will notify my therapist immediately if anything about the treatment feels uncomfortable at any time.

Signed:_____ Date: _____