Inherent Health

INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I understand that the Osteopathic Manual Therapist is providing osteopathic manual therapy services within their scope of practice.

I hereby consent to my Osteopathic Manual Therapist to treat me with Osteopathic manual therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Manual Therapist.

I acknowledge that the Osteopathic Manual Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments 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 that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Osteopathic Manual Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Therapist and have disclosed to the Osteopathic Manual Therapist all of those medical conditions affecting me. It is my responsibility to keep the Osteopathic Manual Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Osteopathic Manual Therapist to release or obtain information pertaining to my conditions(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Osteopathic Manual Therapist from time to time, to deal with my physical conditions and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

Patient Printed Name Signature of Patient / Guardian

_____ _____

Osteopathic Manual Therapist Date Signed

Inherent Health

Name: _____ Birth Date_____ Date_____

Address:_____ _____
City Province Postal Code

Home Phone: (____)_____Work (____)_____Ext_____Cell (_____)_____

Occupation/Work_____

CONTACT IN CASE OF EMERGENCY: _____ Relationship_____

Home Phone: (____)_____Work (____)_____Ext_____Cell (_____)_____

Whom may we thank for referring you?_____

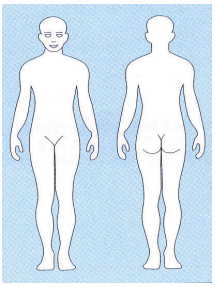
Email address: _____ Would you like to receive our newsletter via email? Yes/no

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

*Mark an **X** on the picture where you continue to have pain, numbness, tingling, discomfort*



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Activities or movements that are painful to perform □Sitting □Standing □Walking □Bending □Lying Down

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy
□ Chiropractic Services □ Massage Therapy □ None □ Other _____

Exercise: □ None □ Moderate □ Daily □ Heavy

Work Activity: □ Sitting □ Standing □ Light Labour □ Heavy Labour □ Mixed

Habits: □ Smoking Packs/day: _____ □ Alcohol Drinks/Week: _____
□ Coffee/Caffeine Cups/Day: _____ □ High Stress Level Reason_____

Injuries/Surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Surgeries		
Birth Trauma/Injury		

Do you have any pins or plates? _____ If yes, where? _____

Medication(s)	**Allergies**	**Vitamins/Herbs/Minerals**