OTTAWA OSTEOPATHY & SPORTS THERAPY
PREVENTION TREATMENT PERFORMANCE

Patient Information

Personal Information	
First Name:	Date of Birth (D/M/Y): Age:
Last Name:	Address:
Telephone Home:	City & Province:
Telephone Cell:	Postal Code:
Telephone Work:	Emergency Contact Name:
Email:	Emergency Contact Relationship:
	Emergency Contact #:

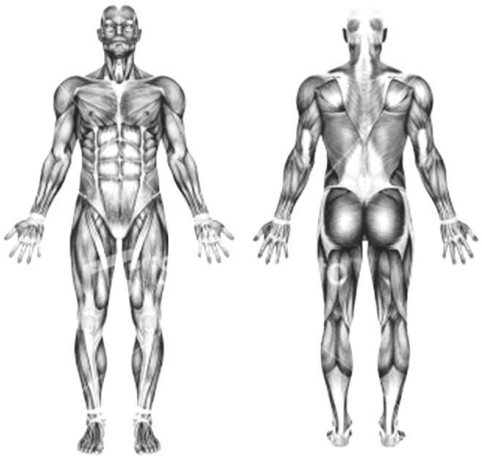
Work	Sport & Hobbies
Employer:	Sports:
Occupation:	Activities & hobbies:
# of years at this type of work:	# of years in this sport/activity:
Type of work (physical, repetitive movement, computer):	Level of competition (rec/club/national/pro):

Do you have children? If so, how old are they?
Who supports you when you are in pain?

Referral	Physician
How did you hear about us? ☐ From your physician ☐ From another patient (specify): ☐ Other: (*Please provide as much detail as possible*) Have you consulted our clinic in the past? Yes / No	Family physician's name: Phone number and address *(Leave blank if unknown):* Date of last physical checkup:
Insurance	Do you have an extended health insurance provider? Which company:

Using the "Insert" and "Shapes" function on Word, please circle any areas in which you are currently experiencing pain, stiffness, numbness or any other symptoms on the body diagram.

Current presenting symptoms:
When/How did this start?



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What exercise equipment do you have available at home?

Health History

How would you describe your **general health**?

Have you previously been treated in Osteopathy, Athletic Therapy, Physiotherapy, or Massage Therapy? *(Please highlight all that apply)*

Are you currently taking any **medications** (including aspirin, ibuprofen, etc.)? Yes / No
If so, which medications/condition(s)?

Have you had any **surgeries** or **injuries** we should be aware of? Yes / No
If so, please elaborate (including date, treatment received, etc.)

Please put an "x" beside any conditions you are experiencing or have experienced in the past:

Cardiovascular:
___ High blood pressure
___ Low blood pressure
___ Chronic congestive heart failure
___ Heart disease / heart attack
___ History of stroke / TIA's
___ Phlebitis / varicose veins
___ Pacemaker or similar device
___ Poor circulation / loss of sensation
___ Dizziness

General:
___ Pre-Diabetes / Diabetes
___ Epilepsy
___ Cancer
___ Arthritis
___ Digestive issues
___ Allergies (anaphylaxis)
___ Food sensitivities
___ Stress / anxiety
___ Open cuts / sores
___ Bruise easily

Head/Neck:
___ Concussion / head trauma
___ Tension headaches
___ Migraine headaches
___ Fatigue
___ Insomnia
___ Whiplash
___ Jaw pain / TMJ issues
___ Vision impairments
___ Hearing loss

Respiratory:
___ Shortness of breath
___ Asthma
___ Bronchitis
___ Emphysema
___ Sinus infections
___ Chronic cough
___ Seasonal allergies

Infections:
___ Infectious skin conditions
___ Infectious respiratory conditions
___ Tuberculosis
___ Hepatitis
___ Herpes
___ HIV
___ COVID-19/Coronavirus

Musculoskeletal:
___ Bone or joint disease
___ Tendonitis / bursitis
___ Fractured bones
___ Sprains / strains
___ Fibromyalgia
___ Sciatica
___ Scoliosis

Other medical conditions (e.g. pregnancies, hemophilia, osteoporosis, gynecological conditions, mental illness,) **or special notes** (presence of internal pins, wires, artificial joints, special equipment, etc.):

Pelvic:
___ Constipation
___ Abdominal / pelvic pain
___ Ovarian cysts
___ Uterine fibroids
___ Endometriosis / PCOS

I certify that all the above information is accurate and up-to-date

E-Signature or name:
Date:
(typing your name here will have the same effect as if you had signed)

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Symptom Monitor and Pain Questionnaire

We take a whole-person approach to your symptoms. We recognize that pain, bladder/bowel symptoms, muscle spasm and other symptoms have both a physical and emotional component to them. To get to the root of your problem(s), we will be asking you many questions that will help us to fully assess your problem and the impact that it is having on your life. If any of these questions don't apply to you or your symptoms, just leave them blank. Thank you for taking the time to share your story with us!

What makes your pain/symptoms better?

What makes your pain/symptoms worse?

Do you ever have no pain? If so, when?

Have your pain/symptoms spread from the original area of your body?

Are you sensitive to light touch or pressure?

What do you think is causing your problem?

What do you think needs to be done for your problem that has not been done already?

What scares or concerns you most about your problem?

What can you not do because of your problem?

Where do you see yourself in one year and five years with this problem?

How does your condition affect your job?

How does your pain affect your fun/leisure?

What are you hoping to achieve with rehabilitation?

On a scale of 1-10, please rate how <u>bothersome</u> this problem is for you

(Please highlight one number only)

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how <u>hopeful</u> you are that you will be able to correct this problem

(Please highlight one number only)

1 2 3 4 5 6 7 8 9 10

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Cancellation Policy - Please read and sign	
Our clinic requires at least 24 hours' notice for all cancellations and rescheduling. * Cancellations within 24 hours of your appointment will be subject to a cancellation fee (50% of the regular appointment fee) This cancellation fee applies to in-clinic and TeleRehab virtual appointments as well. * Additionally, it is your responsibility as a patient to verify your insurance coverage amounts and exclusions where they exist. We greatly appreciate your respect and cooperation in managing the schedule. Please be ready 10-15 minutes before your appointment time and wear appropriate clothing. Thank you.	
E-Signature or name: (Typing your name here will have the effect as if you signed)	Date:

Privacy Policy Consent Form

Privacy of your personal information is important to Ottawa Osteopathy & Sports Therapy. We are committed to collecting, using, and disclosing your personal information responsibly. Our privacy policy ensures that:

- Your information is kept private (unless required by law)
- We have obtained your consent before sharing your information with other healthcare professionals
- Only necessary information is collected about you
- Storage, retention, and destruction of your personal information complies with existing legislation, and privacy protection protocols
- All of our privacy protocols comply with privacy legislation: the Personal Health Information Protection Act (PHIPA); and standards of our regulatory bodies: the Canadian Athletic Therapists Association (CATA), Ontario Association of Osteopathic Manual Practitioners (OAO), College of Massage Therapists of Ontario (CMTO), College of Kinesiologists of Ontario (CKO) and the College of Physiotherapists of Ontario (CPO).

Use and Disclosure of Personal Information

The clinic will only collect, use, and disclose information about you for the following purposes:

- To assess your health concerns, provide health care, and advise you of treatment options
- To establish and maintain contact with you, and remind you of upcoming appointments
- To send you newsletters, educational materials, and other information mailings
- To allow us to efficiently follow-up for treatment, care and billing
- To communicate with other treating healthcare providers
- To complete or verify claims for insurance purposes
- To comply with legal and regulatory requirements

Informed Consent

Please initial each statement to signify that you have read, understand, and have had all your questions answered sufficiently:

_____ I agree that I am attending Ottawa Osteopathy & Sports Therapy to receive osteopathy, physiotherapy, athletic therapy or massage therapy assessment/treatment. I understand that part or all the assessment/treatment will take place on a secure teleconference platform. I understand that the therapist will conduct an individualized assessment which may include asking me questions and doing a virtual physical and movement exam of the external muscular, vascular and nervous system. The therapist will explain their findings, discuss treatment goals and explain all aspects of care, and I am to ask questions for clarification purposes when needed. I understand I can stop the assessment/treatment at any time and all aspects of osteopathy, physiotherapy, athletic therapy or massage therapy care are optional for me.

_____ I have read fully and understood the attached Privacy Policy from Ottawa Osteopathy & Sports Therapy about the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

_____ I consent to having my therapist complete chart notes in a password protected electronic chart.

_____ I consent to the collection of my personal information (verbal or written) as requested by Ottawa Osteopathy & Sports Therapy and understand that this information is primarily used to guide my assessment, treatment plan and follow-up care, amongst other things, as outlined by the Privacy Policy provided.

_____ I consent to have email communication sent to the email provided above for the purposes listed in the section entitled "Use and Disclosure of Personal Information" in addition to treatment, exercise, outcome measures or appointment questions from my treating therapist. Industry standard privacy precautions are used, but I understand that the use of email may pose a risk to my confidentiality and I accept these risks.

_____ I consent to have Ottawa Osteopathy & Sports Therapy send copies or give verbal reports of my Assessment, Treatment plan, Interim Reports, Discharge Plan, and Follow-up Reports as applicable to the following individuals/organizations, and I further consent to the disclosure and collection of such personal information to/from: _____

Payment for TeleRehab before the appointment time:

_____ I understand that the fees associated with TeleRehab are clearly listed in the online booking portal. **I understand that I am obligated to pay the associated TeleRehab fee *before* my appointment time. This will be done by sending an e-transfer to the following registered auto-deposit email address: payments@ottawaosteopath.com.** I understand that I will receive confirmation from my bank that funds have been deposited. Any service fees or surcharges from my bank are my own responsibility. I understand that TeleRehab sessions will not start unless full payment has been made. ***When sending the e-transfer, you must include the names of both the practitioner and the person receiving the TeleRehab session in the "MESSAGE" section.**

_____ I understand that the clinic will email me a complete and detailed receipt for the TeleRehab service I received and that it may take up to 2 business days to receive this email.

_____ I confirm that I have sent the full fees for my TeleRehab service to payments@ottawaosteopath.com and that the payment reference number given to me by my bank is _____.

Please note: You may complete this closer to your scheduled TeleRehab appointment date, however, the full intake form and e-transfer payment must be completed at least 24 hours in advance of your appointment time.

Statement of Consent

I have reviewed the above privacy policy used by Ottawa Osteopathy & Sports Therapy. I agree that I am giving my informed consent to the collection, use and/or disclosure of my personal information as outlined above, and that I may withdraw this consent at any time.

In the event that I wish to withdraw my consent, I understand that it is my responsibility to inform Ottawa Osteopathy & Sports Therapy in writing and that I may do so without prejudice.

I fully understand the above consent statements and am entering into them voluntarily, as certified by my signature:

Client Name: _____
(Typing your name here will have the effect as if you signed)

Client Signature: _____
(or parent/guardian, if patient is under 16)

Date: _____

Witness: _____

Signed in Ottawa, Ontatio

Please note that the electronic copy of this consent form will have the same authority as the original. The original form is not to be removed from the client's file at Ottawa Osteopathy & Sports Therapy

Please email this completed intake form to your therapist at least 24 hours in advance so that they will have time to review it.

Geneviève Renaud (Physiotherapy) Gen@ottawaosteopath.com

Sara Roy (Physiotherapy) Sara@ottawaosteopath.com

Richard Gregory (Osteopathy and Athletic Therapy) Richard@ottawaosteopath.com

Shauna Ironside (Osteopathy and Athletic Therapy) Shauna@ottawaosteopath.com

Neil Price (Osteopathy) Neil@ottawaosteopath.com

Pauline Costa (Osteopathy) Pauline@ottawaosteopath.com

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