OTTAWA OSTEOPATHY & SPORTS THERAPY
PREVENTION TREATMENT PERFORMANCE

Patient Information

Personal Information

First Name:

Last Name:

Telephone Home: ( )

Telephone Cell: ( )

Telephone Work: ( ) ext.

Email:

D M Y

Date of Birth: / / Age:

Address:

City & Province:

Postal Code:

Preferred Pronouns: HE SHE THEY Other:

Preferred name (nickname/short form):

Reason for today's visit:

Emergency Contact Name:

Emergency Contact Number: ( )

Work

Employer:

Occupation:

Number of years at this type of work:

Type of work (physical, repetitive movement, computer):

Sport

Sports / Activities:

Number of years in this sport/activity:

Level of competition (rec/club/national/pro):

Referral

How did you hear of our clinic?

☐ From your physician

☐ From another patient (specify):

☐ Other: _____

(*Please provide as much detail as possible*)

Physician

Family physician's name:

Phone number and address:
(Leave blank if unknown)

Date of last physical checkup:

Have you consulted our clinic in the past? Yes / No

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)**

*** 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 arrive 5-10 minutes before your appointment time and wear appropriate clothing. Thank you.

Signature: **Date:**

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A | 2197 Riverside Drive, Suite 601 Ottawa, ON K1H 7X3
www.ottawaosteopath.com

Health History

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

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

Are you currently in treatment with another healthcare practitioner? Yes / No
If so, for what condition(s)? _____

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 a checkmark 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

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

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

Infections:
___ Infectious skin conditions
___ Infectious respiratory conditions
___ Tuberculosis
___ Hepatitis
___ Herpes
___ HIV

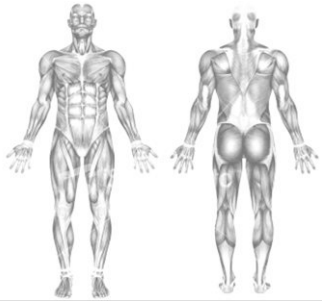
Head/Neck:
___ Concussion / head trauma
___ Tension headaches
___ Migraine headaches
___ Fatigue
___ Insomnia
___ Whiplash
___ Jaw pain / TMJ issues
___ Vision impairments
___ Hearing loss

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

Using the diagram, please circle any areas in which you are <u>currently</u> experiencing pain, stiffness, numbness or other symptoms.



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

Signature: **Date:**

Clinic Use Only

Updated	Initials	Updated	Initials	Updated	Initials
_____	_____	_____	_____	_____	_____

OTTAWA OSTEOPATHY & SPORTS THERAPY

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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), 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

Statement of Consent

I have reviewed the 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.

_____

Patient's Signature *(or parent/guardian, if patient is under 16)*

_____

Date