MiracleHealth

Update 1 _____
Update 2 _____

Confidential Client Case History Form

Please print clearly **Today's Date:** _____

Name: _____ ❒ Male ❒ Female

Address: _____ City: _____ Province: _____

Postal Code: _____ Home Phone: _____ Work/Cell Phone: _____

Birth Date: (m)_____(d)_____(y)_____ Occupation: _____

Medical Doctor: _____ Doctor's Phone #: _____

Emergency Contact: _____ Phone Number: _____

Email: _____

How did you hear about us: ❒Facebook ❒Instagram ❒Google Search ❒Referral ❒Other: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ❒ High Blood Pressure
- ❒ Low Blood Pressure
- ❒ Chronic Congestive Heart Failure
- ❒ Heart Attack
- ❒ Phlebitis / Varicose Veins
- ❒ Stroke / CVA
- ❒ Pacemaker or Similar Device
- ❒ Heart Disease
- ❒ Poor Circulation
- ❒ Hemophilia

Is there a family history of any of the above?
❒ Yes ❒ No

Head and Neck
- ❒ History of Headaches
- ❒ History of Migraines
- ❒ Vertigo or Dizziness
- ❒ Vision Problems
- ❒ Vision Loss
- ❒ Ear Problems
- ❒ Ringing in Ears
- ❒ Hearing Loss

Reproductive
Women
- ❒ Pregnancy
  Due Date: _____
- ❒ Previous Pregnancy Complications:

_____
- ❒ Menopausal Problems: _____

_____
- ❒ Menstrual Problems: _____

_____
- ❒ Gynecological Conditions: _____

_____

Men
- ❒ Enlarged Prostate
- ❒ Libido Issues
- ❒ Other: _____

_____

Respiratory
- ❒ Asthma
- ❒ Bronchitis
- ❒ Emphysema
- ❒ Chronic Cough
- ❒ Shortness of breath
- ❒ Sinusitis
- ❒ Frequent Colds
- ❒ Smoker

Is there a family history of any of the above?
❒ Yes ❒ No

Digestive
- ❒ Constipation
- ❒ Crohn's Disease
- ❒ Colitis
- ❒ Irritable Bowel Syndrome (IBS)
- ❒ Ulcers
- ❒ Other Digestive Conditions:

_____

_____

Infectious Conditions
- ❒ Hepatitis
- ❒ HIV / AIDS
- ❒ Herpes
- ❒ Tuberculosis
- ❒ Lyme Disease
- ❒ Infectious Skin Conditions
  Describe: _____
- ❒ Other Infectious Skin Conditions: _____

_____

Skin Conditions
- ❒ Eczema
- ❒ Psoriasis
- ❒ Rash
- ❒ Warts
- ❒ Open Sores

Nervous System
- ❒ Sensory Loss / Change
  Where? _____
- ❒ Numbness / Tingling
  Where? _____
- ❒ Sciatica
- ❒ Epilepsy
- ❒ Seizures
- ❒ Multiple Sclerosis

Musculoskeletal System
- ❒ Arthritis
  Is there a family history of arthritis?
  ❒ Yes ❒ No
- ❒ Osteoporosis
- ❒ Tendonitis
- ❒ Bursitis
- ❒ Jaw Pain (TMJ)
- ❒ Pins / Plates / Wires / Artificial Joints
  Where? _____

_____

Other Conditions
- ❒ Cancer
  Type/Location: _____

_____
- ❒ Diabetes
  *Onset:*_____
  Type: _____
- ❒ Unexplained Weight Loss
- ❒ Fibromyalgia
- ❒ Chronic Fatigue Syndrome
- ❒ Scoliosis
- ❒ Polio / Post-Polio
- ❒ Hyperthyroid
- ❒ Hypothyroid
- ❒ Depression
- ❒ Anxiety
- ❒ Psychiatric Disorder:

_____

_____

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Update 1 _____
Update 2 _____

Do you have any medical conditions not listed above? ❒ Yes ❒ No
If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?
❒ Yes ❒ No

_____
_____

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort

Face	Upper back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Mid back	Elbow(s)	Finger(s)	Knee(s)	Feet	Shoulder(s)	Lower back
Wrist(s)	Hip(s)	Leg(s)	Toe(s)	Chest	Ribs	Tailbone

_____

For what condition or reason are you seeking treatment today? _____

Have you seen any other health care professional(s) for this condition or reason? ❒ Yes ❒ No
If yes, whom? _____

Have you ever been involved in any motor vehicle accidents? ❒ Yes ❒ No Date: _____
Have you been involved in any other accidents? ❒ Yes ❒ No Date: _____
Have you ever been knocked unconscious? ❒ Yes ❒ No Date: _____

Briefly list any surgeries you have undergone, for what and when.

_____
_____

Are you presently taking any prescribed medication(s)? ❒ Yes ❒ No
If yes, please list the medication(s) and the condition(s) for which it is being used if known.

_____
_____

Have you previously received physical therapy treatments? ❒ Yes ❒ No
If yes, who were you treated by:

❒ Massage Therapist ❒ Osteopath ❒ Physiotherapist
❒ Chiropractor ❒ Acupuncturist ❒ Other: _____

Please circle on the following scales the extent to which you are currently satisfied with the following:
(*5 represents total satisfaction, 1 represents little or no satisfaction*)

Physical health & fitness	**5**	**4**	**3**	**2**	**1**
Mental & emotional happiness	**5**	**4**	**3**	**2**	**1**
Energy level	**5**	**4**	**3**	**2**	**1**
Diet	**5**	**4**	**3**	**2**	**1**
Ability to relax	**5**	**4**	**3**	**2**	**1**

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Client Consent for Osteopathic Treatment

The Osteopathic Manual Practitioner (OMP):

An Osteopathic Manual Practitioner is a highly trained health care provider whose treatment benefits the body in many ways by using a holistic and preventative approach. The basic premise of Osteopathy is that the bodies form directly influences its function. Once the body's structure has been improved or corrected through Osteopathic treatment, there is a marked increase of higher function within the body. This overall improvement in health is the goal for the Osteopathic Manual Practitioner.

Osteopathy is a very gentle manipulation process that is safe for all age groups. There are many reasons to see an Osteopathic Manual Practitioner such as; improved immune function, increased joint mobility, improved posture, decreased pain, and headache relief.

Osteopathic Treatment:

Your practitioner will review your current health condition and will ask you important questions. Your physical examination will include a close inspection of your body's structure to determine the level of dysfunction. This is achieved by palpation, range of motion tests, both visual and physical detections for abnormalities in the muscle, bone, joints, ligaments, connective tissues, and skin tissues. There will be specific orthopedic tests that may be conducted at times. The level of dysfunction that is concluded will determine the level of treatment that is needed. Techniques will range from a very light touch to a deeper, more increased pressure. There may also be recommendations for home care such as muscle stretches and exercises that will support the practitioner's treatment.

All Manual Osteopathic procedures are completed while the patient is fully clothed. However, if it is necessary, your practitioner may only uncover the part of the body they are working on in order to facilitate treatment and to ensure your modesty is respected. If you do not feel comfortable with any part of the treatment, please inform the practitioner immediately. The techniques can be discontinued or modified to be comfortable for you.

Treatment Risks:

Osteopathy is a very gentle manipulation process. In more common cases, patients may experience mild muscle soreness, fatigue, or tenderness similar to excessive sports activities. This vital reaction to treatment usually resolves within a few days. Utilizing gentle techniques further reduces the occurrences of rare complications associated with high velocity treatment. **If you are pregnant or are unsure, please inform us immediately.**

I hereby consent to the performance of Osteopathic Manual Therapy performed by the Osteopathic Practitioner named. I have the right to discuss any questions or concerns that I have regarding my condition and any forms of therapy to be administered. I understand that treatments may include manual therapies where the health practitioner places his hands on the body. If intraoral work is required (work inside the mouth), disposable latex-free gloves will be worn. I understand that the results are not guaranteed. I understand and am informed that there are some risks to treatment.

I have read the above consent and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

Late Cancellation and No-Show Policy:
If an appointment is missed without 24 hours notice, you will be billed a Cancellation/No-Show fee of $30.00 for the time booked. This fee will need to be paid before receiving future treatments. Initial: ___

Patient's Name: _____ Date: _____
(Please Print)

Signature: _____ Witness of Signature: _____