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Patient Intake Form

Name:_____
Address:_____
City:_____ Postal Code:_____
Phone (Home):_____ Phone (Cell):_____
Occupation:_____ Email:_____
Date of Birth:_____ Emergency Contact:_____
Relation:_____ Phone:_____

Are you currently under the care of?
Doctor ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐
Other ☐ _____
Family Doctor:_____ Phone:_____
Date of last medical exam:_____

Reason for osteopathic visit: Prevention ☐ Pain ☐
Other ☐ _____

Primary health concern:_____
Pain relief methods: _____
Causes of worsening pain:_____
The pain is: Constant ☐ Occasional ☐ Progressive ☐ Sudden ☐
The pain occurs during: Morning ☐ Day ☐ Night ☐
Origin of symptoms: Accident/fall ☐ Progressive Increase ☐ Sudden ☐ Unknown ☐
Have you consulted a doctor: Yes ☐ No ☐
What was the diagnosis?_____
Are you physically active?_____
Do you sleep well? Yes ☐☐ No ☐☐ I wake up a lot ☐☐ I wake up tired ☐☐

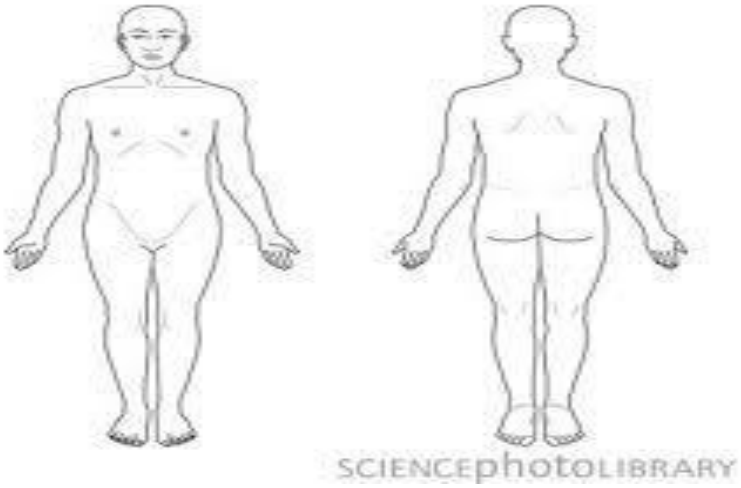
Surgeries (Explain)

_____
_____

Accidents/Injuries (explain)

_____
_____

Please indicate on the figures below the location of your pain



Please list any prescription medications you are currently using:

<u>Indicate with a "C" if you currently experience any of these below, and "P" if you did in the past:</u>

Gastrointestinal:

___ Abdominal Cramps ___ Acid Reflux ___ Bloating
___ Colitis ___ Constipation ___ Crohn's Disease
___ Diarrhea ___ Flatulence ___ Heartburn/Indigestion
___ Hemorrhoids ___ Hernia/Hiatal/Inguinal/Umbilical
___ Hypoglycemia ___ Liver Disease ___ Pancreas
___ Ulcers ___ Other: _____

Head and Neck:

___ Allergies ___ Cervical Herniated Disc
___ Dry Eyes ___ Ear Aches ___ Ear Infection
___ Eye Pain ___ Glaucoma ___ Headaches
___ Head Injury ___ Impaired Hearing ___ Jaw Problems
___ Laryngitis ___ Migraines ___ Ringing in Ears
___ Other: _____

Cardiovascular and Neurological:

___ Angina ___ Anxiety ___ Chest Pain
___ Concussion ___ Cold hands & feet ___Congestive heart failure
___ Depression ___ Dizziness ___ Fainting
___ Fibromyalgia ___ High Blood Pressure ___ High Cholesterol
___ Irregular Heart Beat ___ Low Blood Pressure ___ Multiple Sclerosis
___ Myocardial Infraction ___ Numbness or Tingling ___ Pacemaker

___ Phlebitis ___ Swelling of Limbs ___ Varicose Veins
___ Stroke/Cardiovascular accident (Explain) _____
___ Other: _____

Muscle, Bone and Joint:
___ Bursitis ___ Broken Bones ___ Herniated Disk
___ Joint Pain ___ Joint Swelling ___ Lower Back Pain
___ Osteoarthritis ___ Osteoporosis ___ Rheumatoid arthritis
___ Sciatica ___ Scoliosis ___ Sprain
___ Strain ___ Tendinitis
Other: _____

Respiratory System:
___ Asthma ___ Bronchitis ___ Chronic Cough
___ Chronic Mucus/Phlegm ___ Difficulty breathing in/Inspiration ___ out/expiration
___ Pain when Breathing ___ Pneumonia ___ Shortness of Breath
___ Other: _____

Female:
___ Abortion ___ Breast Pain ___ Endometriosis
___ Fibroids ___ Fibrocystic Breast ___ Ovarian Cyst
___ Pain during Intercourse ___ Painful Menstrual Cycle ___ PMS
___ Sexual Dysfunction ___ Vaginitis ___ Yeast Infections
___ Are you Pregnant? ___ Number of Pregnancies ___ Miscarriage
___ Other: _____

Male:
___ Andropause ___ Hernia ___ Inguinal Pain
___ Pain during intercourse ___ Prostatitis ___ Prostate Enlargement
___ Sexual Difficulties ___ Other: _____

Urinary System:
___ Frequent Urination ___ Incontinence ___ Kidney Infection
___ Kidney Stones ___ Pain ___ Urgency to Urinate
Other: _____

Skin and Hair:
___ Eczema ___ Hives ___ Psoriasis
___ Rash ___ Rarely Perspire ___ Excessive Perspiration
Have you had skin conditions/lesions removed or biopsied? Yes ☐ No ☐

Infections:
___ Hepatitis ___ HIV/AIDS ___ Tuberculosis
Other: _____

Endocrine:
___ Adrenal Disorder ___ Diabetes ___ Goiter
___ Hyperthyroidism ___ Hypothyroidism
Other: _____

Cancer, please explain: _____
_____

CONSENT/ CONFIDENTIALITY

- All information recorded above is give by me, and is to the best of my knowledge and belief, complete and true. I understand that the recorded medical history is important for a safer and more effective treatment, and will be kept strictly confidential.
- I understand that, Johanne Lavergne, D.O.M.P. is an osteopath, and not a medical doctor.
- The osteopathic approach by the practitioner was discussed before the treatment and consent was given.
- I am aware that it is possible and normal to have discomfort from the treatment such as muscle aches or soreness or fatigue. Nevertheless, if it persists over 48 hours, I should call the office of Lavergne osteopathic treatment.
- I understand that, if I am late for my treatment, I will only receive the remaining time of my session.
- Patients under 18 years old must be accompanied by a parent or legal guardian for initial treatment and must co-sign this document. If a patient is under 16, a parent or legal guardian must be present for all treatments.
- No information in my file will be given to anyone without my written consent.
- I realize that there could be a charge if I do not give a 24 hours notice to cancel
- I have stated all medical conditions I am aware of and will provide an update of any changes in my health status.

Signature: _____ date _____

Signature du parent / guardian :_____