Osteopath New Patient Form

Date­­ ­\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

## Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  |  |  |
| DOB |  | Occupation |  |
| Address |  |  |  |
| Email |  |  |  |
| Phone |  |  |  |
| GP |  | Referral | Y / N |
| Do you have a referral for an EPC/CDMP program? | Y / N |  |  |
| Is your visit today part of a TAC/Workcover treatment plan? | Y / N |  |  |

## Reason For Treatment

|  |  |  |
| --- | --- | --- |
| What is your main reason for treatment today? |  |  |
|  |  |  |
|  |  |  |
| Have you seen other health professional for your current complaint (eg GP, Physio, Osteopath)? |  |  |
|  |  |  |
| Have you had any scans/images performed for your complaint? |  |  |
|  |  |  |
|  |  |  |
| Have you tried any rehabilitation for your complaint (eg Exercise, stretching, pilates)? |  |  |
|  |  |  |
|  |  |  |
| Have you taken any medication for your complaint? |  |  |
|  |  |  |

## Long-term goals

|  |  |  |
| --- | --- | --- |
| Please list your goals regarding for current complaint and overall health (eg Be pain-free, able to play sport, restore lost range of motion, improve quality of life) |  |  |
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## Activity

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| --- | --- | --- |
| Please list your weekly exercise (This can include lawn mowing and walking) |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| How much time do you spend exercising a week? |  |  |
| Is there exercise you would like to start doing? |  |  |
|  |  |  |

## Medication

|  |  |  |
| --- | --- | --- |
| Are you currently taking any prescription medication? |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Are you currently taking any supplements? |  |  |
|  |  |  |
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|  |  |  |

## Medical Screen

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| --- | --- | --- |
| Do you have any health conditions? (Please list) |  |  |
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|  |  |  |
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|  |  |  |
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## Hospitalisations

|  |  |  |
| --- | --- | --- |
| Have you ever been admitted to hospital? (EG Injury, childbirth, surgery, car accident, psychiatric condition) |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Mental Health

|  |  |  |
| --- | --- | --- |
| Have you been diagnosed with a mental health condition? |  |  |
|  |  |  |
|  |  |  |
| Do you have a psychologist or mental healthcare worker who supports you? | Y / N |  |

## Sleep

|  |  |  |
| --- | --- | --- |
| Average hours sleep a night? |  |  |

## Do you have any other concerns or want to mention anything else before your appointment

|  |  |  |
| --- | --- | --- |
|  |  |  |
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Osteopath Patient Consent Form

When performed by qualified practitioner, Osteopathy is considered a safe and effective treatment method of many musculoskeletal conditions. Many patients experience immediate relief post treatment.

There are, however, some risks associated with manual Osteopathy treatment.

Some patients may experience mild soreness or aching post treatment, just as they do after vigorous exercise or massage. Current literature shows that minor discomfort or soreness following soft tissue therapy typically fades within 24hours.

There is a slight risk of more serious injuries including, but not limited to, muscle and joint strains, nerve pain and/or referral, fractures, disc injuries and strokes.

Many techniques will involve contact between your body and the practitioner’s body. Body and hand contact may include areas of your chest wall, gluteal muscles, and pubic bones. If intraoral is required (work inside the mouth) disposable latex or vinyl gloves will be worn.

At times, the practitioner may ask you to remove some items of clothing in order to facilitate assessment and treatment. If you do not feel comfortable with any part of the treatment, please inform your practitioner immediately. The techniques can always be modified as per consent.

**Please Complete:**

\_\_\_\_ I have informed the Osteopath of all my known physical conditions, mental conditions, and medications and I will keep the practitioner updated on any changes.

\_\_\_\_ I understand that there are possible risks and benefits of Osteopathy and that they have been explained to me regarding my individual treatment plan and accept responsibility of informing my practitioner if I do not understand any aspect of the risks and benefits.

\_\_\_\_ I freely consent to participate in all the procedures involved in the care plan.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to all procedures mentioned above,

Print Name (patient/parent/guardian)

Except for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature Today’s Date