WELCOME TO BUSSELTON OSTEOPATHIC CLINIC

The information completed on this form is strictly confidential.
No release or information will be given without prior permission of the patient.

Last name: _____ First:_____Middle:_____

Street address:_____Home phone:_____

Suburb: _____Postcode:_____Mobile:_____

Occupation:_____Work phone:_____

Email address:_____Health cover:_____

Blood type:_____Height_____cm Weight_____kg Date of birth:_____

Medical practitioner:_____Marital status:_____

Recommended by:_____Children:_____

What is the main reason for your visit today? _____

Please indicate the intensity of your pain on this scale (tick or circle one)

None 1 2 3 4 5 6 7 8 9 10 **Worst ever**

How long have these problems been present? _____ Days/Weeks/Months/Years

Have you had treatment for these problems?_____If so, from whom_____

Results of this treatment? _____

Is your injury, pain or illness related to either work or a motor vehicle accident? Yes/ No /Not sure

If "yes", then is either Work-Cover or M.V.I.T. involved? Yes/ No/ Not sure

If "yes", which?_____

If you have a claim number for this injury , please write it here_____

Employer:_____
Name address phone number

Please bring any medical reports, including x-rays, CT scans, MRI, blood tests.

I understand that there is a fee for missed appointments. Payment is due when the service is performed.

Patient Signature:_____ Date:_____

INFORMED CONSENT TO OSTEOPATHIC CARE

When performed by a qualified Osteopath, spinal manipulation is an effective and safe method of treatment for many painful conditions. There are, however, risks associated with any treatment, and I am required to inform you of these, even though there has never been a case in this clinic. Please read the following carefully and write down any questions you may have.

I hereby request and consent to the performance of osteopathic treatment on me by Dr Yvan Ducat, Dr Kamisha Cleaver and/or any other Osteopath working in this clinic authorised by Dr Yvan Ducat.

I have had the opportunity to discuss the nature and purpose of osteopathic treatment with the Osteopath.

I understand that results are not guaranteed.

I understand, and am informed, that as in the practice of medicine, in the practice of osteopathy there are some very slight risks to treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, strokes and stroke like episodes.

I do not expect the Osteopath to be able to anticipate and explain all risks and complications and I wish to rely on the Osteopath to exercise judgement during the course of treatment, which the Osteopath feels at the time, based upon the facts then known and is in my best interests.

I have read the above and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover the entire course of treatment for my present condition, and for other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

Dr Yvan Ducat
D.O. Osteo

Dr Kamisha Cleaver
Ba.ClinSci.M.Ost

_____
Patient's Signature

_____
Patient's Name

Date: _____

Osteopathy assists the body to heal itself.
Your answers to this questionnaire will provide a health profile to better understand and help you.

Please indicate any condition(s) you are experiencing, or have experienced:

General

☐Have you had a recent health check from a GP?

Cardiovascular

☐Racing or irregular heart beat
☐Pain or pressure in chest, neck or arm
☐High blood pressure
☐Low blood pressure
☐Heart attack
☐Stroke/CVA
☐Pacemaker or similar
☐Heart disease

Neurological

☐Vision problems
☐Ear problems
☐Dizziness
☐Headaches/migraines
☐Head injuries (ever been concussed or unconscious)
☐Seizures

Gastrointestinal

☐Change in weight or appetite
☐Nausea/vomiting
☐Change in bowel habits
☐Loss of control of bowels
☐Irritable bowel syndrome
☐Pain, discomfort or pulsating in abdomen

Endocrine

☐Increased thirst, hunger or urination
☐Swelling in the neck
☐Diabetes

Genitourinary

☐Bloody dark, cloudy or frothy urine
☐Genital pain, lumps or discharge

FEMALES ONLY
☐Last pap smear? _____
☐Menstrual problems (excessive pain or bleeding, irregular periods or bleeding between periods)
☐Menopause
☐Pregnant: how many wks?___ Due date?_____
☐Previous pregnancies
How many children do you have? ____
Vaginal or caesarean birth/s?_____

MALES ONLY
☐Delayed, slowed or dribbling urine stream
☐Prostate issues
☐Prostate check?

Respiratory

☐Shortness of breath
☐Chronic cough
☐Bronchitis
☐Asthma
☐History of nose, throat or lung disease

Skin

☐Skin problems _____

Infections

☐Hepatitis
☐Tuberculosis
☐HIV
☐Ross river/ BFV

Joints and Muscles

☐Arthritis
☐Inflammation
☐Weakness
☐Numbness
☐Pins and needles

Other

☐Allergies
☐Recent vaccinations
☐Cancer: Type_____
☐Car or cycle accident
☐Concussion/Unconscious
☐Emotional trauma/ depression/ anxiety
☐Dental work (braces, teeth removed, denture)
☐Do you have any body piercings?
☐Do you drive a Hybrid car?
☐Rate your wireless technology use from 1-10 _____ (mobile phones, tablets, wifi etc.)
The central nervous system is affected by the electro-magnetic field emanating from the battery and wifi router. This may lead to headaches and fatigue and reduced cranial function.

Other medical conditions not listed above:

Current medications and what they are used for:

Previous hospitalizations/surgeries (nature and date):

Injuries (nature and date):

Family health history (genetic or hereditary illnesses):

Thank you for completing this history form