NEW PATIENT FORM

Osteopathy

Please read and complete this form carefully. The information will be kept confidential.

PERSONAL DETAILS

Name _____ Date of Birth _____ Sex M ☐ F ☐

Address _____ Email _____

_____ Postcode _____ Occupation & Employer _____

Phone M _____ GP's Name/Clinic _____

W _____ Emergency Contact _____

H _____ Emergency Contact Phone _____

How did you hear of us? ☐ Friend/Family (name) _____

☐ Google/Search engine ☐ Bicycle ☐ Doctor Referral (name) _____

☐ Facebook ☐ Poster ☐ Other (details) _____

HEALTH HISTORY

What are your goals (or 2 main reasons) for today's consultation? _____

_____

List any injuries, accidents, operations _____

_____

List any medications or supplements you are currently taking _____

_____

Please mark below any conditions that apply (and if necessary, briefly explain)

☐ High/Low Blood Pressure ☐ Heart attack/Chest Pain ☐ Headache/Migraine ☐ Stroke

☐ Asthma/Breathing difficulties ☐ Dizziness/Fainting ☐ Arthritis ☐ Cancer

☐ Allergies/Food intolerance ☐ Osteoporosis/Osteopenia ☐ Pregnant ☐ Other

Other details _____

Family history of any of the above _____

Do you see any other health professionals? ☐ Personal Trainer ☐ Massage ☐ Pilates ☐ Yoga

If yes, please provide details* Name _____ ☐ Other professional _____

Email _____ Phone _____

*This information enables your practitioner to communicate with other health professionals to help improve your outcomes.

melbourne osteopathy
SPORTS INJURY CENTRE

TERMS AND CONDITIONS AND INFORMED CONSENT TO OSTEOPATHIC TREATMENT

When performed by a qualified practitioner, osteopathic manipulation of the spine & other joints, muscles and other parts of the musculoskeletal system is an effective and safe method of treatment for many conditions. There are, however, risks associated with any treatment that we are required to inform you of.

Please read the following carefully and discuss any questions you may have with your treating practitioner. If you agree, please fill out the name of your osteopath, sign and return this form to them.

I request and consent to the performance of osteopathic manipulation and other osteopathic procedures.

I confirm that I have had the opportunity to discuss with the osteopath named below the nature and purpose of osteopathic manipulation and other osteopathic procedures. I understand that results are not guaranteed.

I understand, and acknowledge that in the practice of osteopathy, as in all medicine, there are some very slight risks to treatment including, but not limited to, muscle & joint soreness, muscle & joint strains, fractures, disc injuries and strokes. I do not expect the osteopath to be able to anticipate and explain all of the risks and possible complications. I wish to rely on them exercising their judgment during the course of my treatment in the manner that is in my best interests, based on the facts then known.

I consent to photo and video recording where deemed appropriate by the osteopath for biomechanical assessment.

I have read the above, and confirm that 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 any other future condition(s).

I understand that I can withdraw my consent at any time in writing.

Future appointments at this clinic may be required to be **block booked** to ensure the optimal outcome for your condition, illness or injury.

I consent to receiving appointment reminders (by SMS and email) and other information from time to time regarding the services of Melbourne Osteopathy Sports Injury Centre and that I can opt out of these notifications if requested.

This clinic has a **24 hour cancellation policy** that applies to all appointments. Failure to provide 24 hours notice when changing or cancelling appointment times and missed appointments will result in being charged the full appointment fee. It is expected that you will pay for each appointment at the end of your session.

If you are happy with your consult we would appreciate it if you could **refer friends and family** to our centre.

At the end of your first treatment we request that you complete a **patient feedback form**.

Osteopath's Name _____

Patient's Name _____ Patient's Signature _____

Date: _____