Chiropractic
Acupuncture
Massage Therapy
Foot Orthotics
Naturopathic Medicine

KING WEST CHIROPRACTIC HEALTH CENTRE
145 King St. West, Concourse Level Toronto,ON M5H 1J8 Tel: 416-815-9595 Fax: 416-815-9009
Email: info@kingwestchiropractic.com www.kingwestchiropractic.com

OSTEOPATHY INTAKE AND CONSENT FORM

Name: _____

Address: _____ Unit #_____

City: _____ Province: _____ Postal Code: _____

Phone (H): _____ (Bus.): _____ (Cell)_____

E-mail: _____

Date of Birth: _____

Occupation: _____ Primary Complaint: _____

Height: _____ Weight: _____ Blood Pressure: _____ Resting Pulse: _____

Please list presence of any internal pins, wires, artificial joints or special equipment: _____

Please list any allergies: _____

Name of Medical Doctor: _____ Phone: _____

How did you hear about us? ❒ Doctor ❒ Other Health Practitioner ❒ Website ❒ Signage
❒ Word of Mouth ❒ Other: _____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your main reasons for seeking treatment today (e.g. low back pain, headaches, etc.)?

_____
_____
_____

Prescription Drugs

List all prescription drugs that you are currently taking. Please indicate what the prescription is for.

_____
_____

Medical History

List any surgeries and when they occurred:

_____
_____

List any fractures and when they occurred:

_____
_____

List any major accidents and when they occurred (including car accidents) :

_____
_____

Have you ever been knocked unconscious or taken a significant blow to the head? Please circle:

Yes / No If yes, please state when: _____

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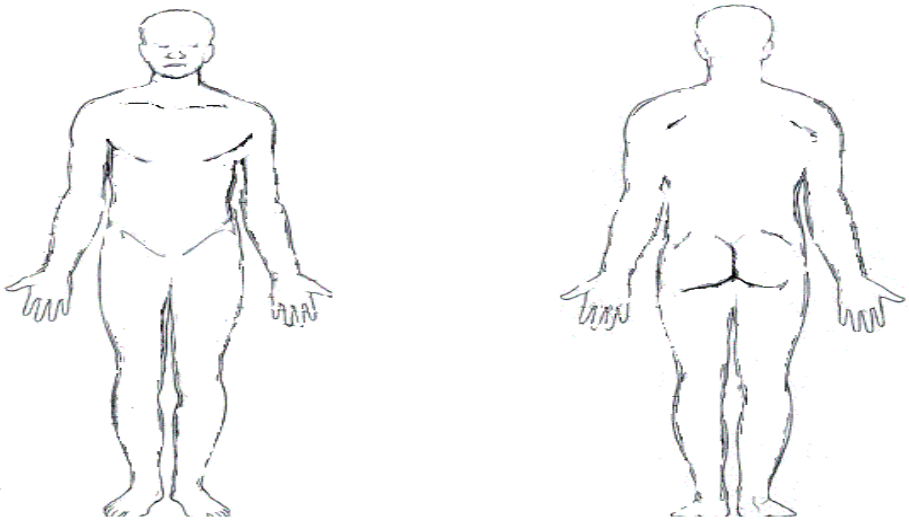
Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain:

No pain at all _____ As bad as it could be

Pain Diagram - On the following diagrams, indicate all areas of:
Pain – xxxx Stiffness - //// Numbness – 0000 Other (specify) - _____



Medical History

In the lists below, check all the areas you are currently experiencing, and place a 'P' in the box of areas you have experienced in the past.

General Symptoms

- ☐ Headaches
- ☐ Migraines
- ☐ Loss of Consciousness
- ☐ Blackouts
- ☐ Fever sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions / Seizures
- ☐ Loss of sleep
- ☐ Insomnia
- ☐ Chronic Fatigue
- ☐ Numbness and / or tingling
- ☐ Nervousness / Anxiety
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Weight loss / weight gain
- ☐ Hyperglycemia / Hypoglycemia
- ☐ Hepatitis A / B / C
- ☐ Edema
- ☐ HIV Positive &/OR AIDS
- ☐ Cancer
- ☐ Other: _____

Muscle and Joints

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Jaw pain
- ☐ Arthritis

Eyes / Ears / Nose / Throat

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye pain
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing / buzzing in ears
- ☐ Frequent colds / infections
- ☐ Enlarged glands / thyroid
- ☐ Speech problems
- ☐ Difficulty swallowing

Respiratory

- ☐ Asthma
- ☐ Allergies
- ☐ Sinus problems
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pleurisy

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Cardiovascular

- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Heart attack/myocardial infarction
- ☐ Anemia
- ☐ Stroke/cerebrovascular accident
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Angina
- ☐ Hemophilia / bleeding disorder
- ☐ Circulation problems
- ☐ Varicose veins
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Edema
- ☐ Poor circulation
- ☐ Other: _____

Gastrointestinal

- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Indigestion
- ☐ Ulcers
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gall bladder problems
- ☐ Irritable bowel syndrome
- ☐ Colitis
- ☐ Crohns disease
- ☐ Celiac disease
- ☐ Hiatus hernia
- ☐ Acid Reflux
- ☐ Other: _____

Female

- ☐ Painful menstruation / cramps
- ☐ Excessive flow
- ☐ Irregular cycle
- ☐ Endometriosis
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ STD
- ☐ Other:_____

Menopausal Y☐ N☐
Pregnant Y ☐ N☐

Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

Skin

- ☐ Rashes
- ☐ Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergy)
- ☐ Eczema
- ☐ Psoriasis

Genitourinary

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Urinary tract infection
- ☐ Incontinence
- ☐ Cystitis

Male

- ☐ Prostate problem
- ☐ Impotence
- ☐ Pain
- ☐ Infertility/low sperm count
- ☐ STD
- ☐ Hernia
- ☐ ED

Agreement

I agree that it is my choice to receive osteopathic treatment. I give permission for the therapist to work on all parts of my body (excluding private areas), including areas such as the head, neck and spine, tailbone, rib cage, front of the chest (sternum), abdomen, pelvis, arms and legs. I understand that the parts of the therapist's body may come into contact with mine at times during the treatment. I agree to communicate with my therapist at any time if I feel like my well-being is being compromised or I feel uncomfortable in anyway.

I understand that osteopaths do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that Katrine O'Reilly is not a medical doctor/physician, and that osteopathic treatment is not a substitute for medical examination or diagnosis. It is recommended that I see a primary health care provider for that service. I am also aware that there are no guarantees that these treatment(s) will completely relieve the symptoms for which I have consulted.

I have stated all medical conditions that I am aware of and will update the therapist of any changes in my health status. I understand that this osteopathic treatment is not covered by OHIP. The therapist is not responsible for any billing or dealings with private health insurance companies.

Signature: _____ Date: _____

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OFFICE POLICY

Welcome to King West Chiropractic Health Centre.

Clinic Hours

Chiropractic:	Monday to Friday 8:00 am to 6:00 pm
Massage Therapy:	Monday to Friday 9:00 am to 7:00 pm
Osteopathic:	Monday/Wednesday/Friday 10:00 am to 6:00pm

Insurance

Many benefit plans cover some or all of our services. While our office does not deal directly with insurance companies, we do issue official receipts which may be submitted for reimbursement.

Scent-Free Policy

KWC is a scent-free clinic – please refrain from wearing perfume or cologne.

Massage Therapy and Osteopathy Missed Appointment Policy

24 hours notice is required when
cancelling or rescheduling
massage and osteopathic appointments.

If we are unable to fill the timeslot patients will be responsible for the full fee of the missed appointment.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information is not shared. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your account and clinic updates/promotions.

☐ Please check this box if you consent to receiving our clinic newsletter (sent by email once per month).

Email _____

Patient Signature _____ **Date** _____