ORTHOMED CLINIC AND SUPPLY

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OSTEOPATHIC TREATMENT
CLIENT INFORMATION PACKAGE

Date:_____

Title: [] Mr. [] Mrs. [] Miss. [] Ms.

Gender: []M []F

Full Name_____ **Date of Birth**:_____
day / month /year

Address: _____City:_____

Postal Code_____ Phone: Home: (____)_____ Mobile: (____)_____

Are you taking medication? []Yes []No Describe:_____

Did you have any accidents, hospitalization, surgeries? Yes[] No[] When_____

PLEASE CHECK SYMPTOMS/DISEASES

[] Headaches	[] Neck pain	[] Neck stiffness	[] Muscle tension	[] Face flushed
[] Mid back pain	[] Low back pain	[] Loss of balance	[] Fainting spells	[] Whiplash
[] Disk problems	[] Chest Pain	[] Decreased ROM	[] Cold Sweats	[] Fever
[] Cold feet	[] Cold hands	[] Constipation	[] Arthritis	[] Osteoporosis
[] Pins & Needles in Legs	[] TMJ	[] Fatigue	[] Heart attack	[] Diabetes
[] Pins & Needles in Arms	[] Broken bones	[] Fibromyalgia	[] Stroke	[] Cancer
[] Pins & Needles in Toes	[] High blood pressure	[] HIV	[] Varicose veins	[] Tendonitis

Intestinal

___ Diarrhea	___ Constipation	___ Hemorrhoids	___ Gallstones	___ Gout
___ Colitis	___ Bloody stool	___ Mucous in stool	___ Intestinal pain	___ IBS

Cardiovascular / respiratory

___ Heart palpitations	___ Chest pain	___ Difficulty breathing	___ High cholesterol
___ Varicose veins	___ Blood clots	___ Swollen ankles	___ Heart valve abnormality
___ Shortness of breath	___ Cold hands / feet	___ Dry cough	___ Wheezing
___ Chest tightness	___ Difficult inhalation	___ Difficult exhalation	___ Productive cough

Musculoskeletal

___ Vertebral disc degeneration	___ Joint pain	___ Tendonitis	___ Swelling	___ Arthritis
___ Limited range of motion	___ Osteoporosis	___ Carpal tunnel	___ Numbness	___ Spinal pain

Head, Eyes, Ears, Nose and Throat

___ Dry eyes	___ Blurred vision	___ Poor vision	___ Nosebleed
___ Night blindness	___ Cataracts	___ Macular degeneration	___ Bleeding gums
___ TMJ	___ Sores on tongue or mouth	___ Dry mouth	___ Excess saliva
___ Sinus problems	___ Sore throat	___ Headaches	___ Swollen glands
___ Difficulty swallowing	___ Earaches	___ Tinnitus / ringing	___ Deafness

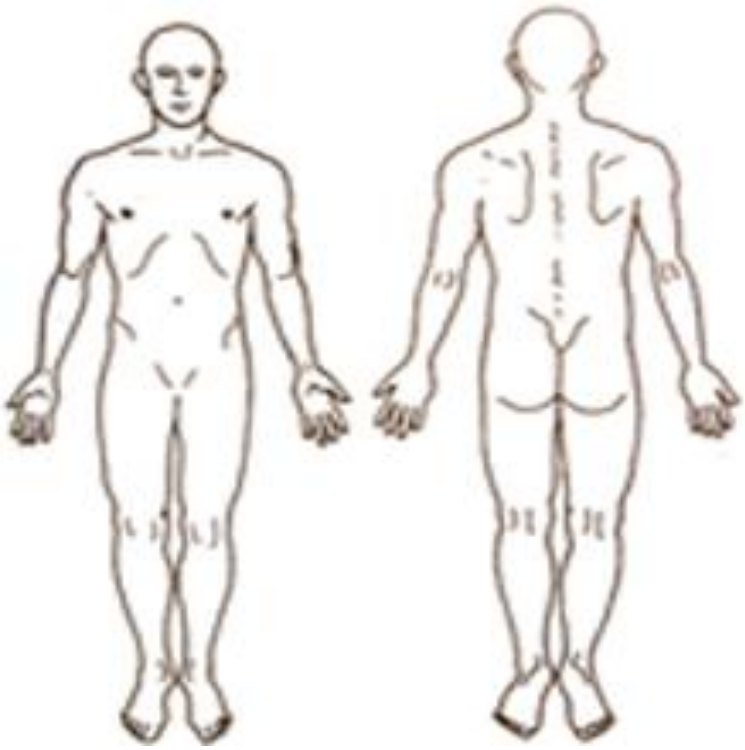
Genito-urinary

___ Frequent urination	___ Loss of urine when laughing or sneezing	___ Dribbling
___ Incomplete urination / retention	___ Burning urination	___ Blood in urine
___ Wake frequently to urinate	___ Kidney stones	___ Bedwetting
___ Decreased libido / sexual desire	___ Impotency	___ Infertility

Neuropsychological

___ Anxiety	___ Irritability	___ Insomnia	___ Depression
___ Easily stressed	___ Poor memory	___ Tics	___ Tremors
___ Seasonal mood disorder		___ Job stress	___ Recent divorce
___ Death of someone close		___ Currently in therapy	___ Financial setback

Pain Drawing: Mark the areas of your body where you feel pain, Include all affected areas, Mark areas of radiation.



WAIVER

I, the undersigned, have read, understand, and have answered the above survey/questions fully and truthfully. I am aware of my responsibilities to consult with my personal physician regarding my medical fitness to engage in exercise. I do herby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the treatment facility and the osteopath professional administering the treatment program provided to me.

INFORMED CONSENT FORM

I understand that there will be one to fifteen treatment sessions. I know that I can request additional treatments, as needed, after that time. I understand that my participation will involve completing several surveys of health distress and pain intensity. I understand that I am not required to fill in a response to any question that I do not feel comfortable answering.

CONSENT FOR OSTEOPATHIC CARE

The Osteopath uses gentle touch, or palpation, to assess and monitor the source of a patient's condition. Osteopaths use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note that while rare, some patients have experienced rib fractures or muscle and ligaments sprains or strains following spinal adjustments. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause strokes, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote (1/400,000-1,000,000.) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments. The risk of injuries or complications from osteopathic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. I acknowledge I have discussed, or have had the opportunity to discuss, with my osteopath the nature and purpose of osteopathic treatment in general and my treatment in particular as well as any questions regarding this Consent. I consent to osteopathic treatments, including spinal adjustments. I intend this consent to apply to all my present and future osteopathic care.

I release ORTHOMED CLINIC AND SUPPLY and a treating osteopath and/or specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice.

CLIENT SIGNATURE_____ Date_____

Parent or Legal Guardian Signature_____ Date_____
(if client is under 18 years of age)