OSTEOCARE CRAIGIEBURN

Osteopathy & Myotherapy

New Patient details form

All information held is in the strictest confidence

Name: ____________________

Address: ____________________

Post Code: __________

Phone (H) ____________________

(W) ____________________

(M) ____________________

Email ____________________

Occupation ____________________

Date of Birth ____________________

Today's Date ____________________

Purpose of visit/ main complaint ____________________

Your GP's name and address ____________________

How did you find out about our Services at OsteoCare Craigieburn?

□ Craigieburn Advertiser □ Sign

□ Yellow Pages □ Internet □ Local Directory

□ Existing client at OsteoCare Craigieburn

□ Friend (Please name) ____________________

□ Other (Please specify) ____________________

Next of Kin Contact details: Name: ____________________

Contact #: ____________________ Relationship: ____________________

Your Health

Have you been to an Osteopath previously? □ yes □ no

Have you been to a Myotherapist previously? □ yes □ no

Do you have any medical conditions? □ yes □ no

If so, what ____________________

Please list current medications and what condition they have been prescribed for ____________________

Have you had any surgery, trauma or hospitalizations? If so, when and for what? ____________________

Tests/ scans/x-rays of current problem? □ yes □ no Please list type of scan and date of imaging ____________________

Your Pain

- Where is your pain? ____________________
- Is your pain Sharp □ Dull □ Aching □ Other ____________________
- Rate the level of your pain (1 is low, 10 is extreme) ____________________
- Is your pain; Constant □ Periodic □ Occasional □ Only felt in bed □ Stiff in morning □ Better with movement □
- Is the pain; Getting worse □ Getting better □ No change □
- When is your pain worse? Bending □ Turning □ Sitting□ Standing □ Lying □ Rising from sitting □ Walking □ Coughing/Sneezing □ Other □ ____________________
- What makes your pain better? Bending □ Turning □ Sitting □ Standing □ Lying □ Rising from sitting □ Walking □ Coughing/Sneezing □ Other □ ____________________
- Do you have any pins and needles, or numbness or weakness anywhere? Yes□ No□ If so where? ____________________
- Have you had this type of pain before? Yes □ No □ If so when and how frequently? Daily □ Weekly □ Monthly □

**The personal information that we collect from you enables us to assess your suitability for treatment and to aid in your treatment. The information will be used for that purpose only and will be kept securely. You have the right to access and amend the information. If the information you have provided is incorrect, please contact us so that we can effect the relevant changes.*

Please complete the Medical History questions on the reverse

Medical History Questionnaire

Do you have high blood pressure?......................□ yes □ no
Have you ever had a stroke or TIA?....................□ yes □ no
Do you take blood thinning drugs ………..……..□ yes □ no
(eg. asprin or warfarin)
Do you take steroids (eg. cortisone)……………..□ yes □ no
Do you take anti-inflammatories?.......................□ yes □ no

Have you ever suffered from

Skin cancer…………………………………………..□ yes □ no
Heart disease……………...……………………...□ yes □ no
Chest pain……………….………………..……...□ yes □ no
Circulation problems ……….…………………...□ yes □ no
Thrombosis/Clots …….……..………………….□ yes □ no
Asthma/ Bronchitis/breathing difficulties…………□ yes □ no
Dizziness, nausea or fainting………………………□ yes □ no
Headaches/migraine………………………………..□ yes □ no
Liver disease/hepatitis ……………………………..□ yes □ no
Epilepsy ……………………………………………..□ yes □ no
Chronic Fatigue Syndrome………………………...□ yes □ no
HIV/AIDS infection…………………………………□ yes □ no
Cancer………………………………………………□ yes □ no
Osteoporosis………………………………………...□ yes □ no
Diabetes……………………………………………...□ yes □ no
Urinary Infections…………………………………...□ yes □ no
Bowel Problems……………………………………□ yes □ no
Arthritis………………………………………………□ yes □ no
Bone Fractures……………………………………...□ yes □ no
Incontinence…………………………………………□ yes □ no
Dental Surgery………………………………………□ yes □ no
Indigestion/heartburn………………………………□ yes □ no
Hearing problems…………………………………...□ yes □ no
Visual problems……………………………………..□ yes □ no
Weight gain/loss……………………………………□ yes □ no
Sinus/ hayfever /allergies…………………………..□ yes □ no
Depression…………………………………………..□ yes □ no
Anxiety………………………………………………..□ yes □ no

Is there any conditions above that you are currently seeking treatment for by your GP or another Health Professional?

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Do you feel that these conditions are being managed well at the moment? ……………………………………..□ yes □ no

Lifestyle

Do you smoke?..□ yes □ no
If so, how many per day for how many years? ____________
Do you take recreational drugs……………………□ yes □ no
If so, which ones? ________________________
Do you sleep on your stomach?............................□ yes □ no
Do you have the usual health checks?..................□ yes □ no
(eg. blood pressure, cholesterol, diabetes, pap smear, breast/ testes examination)
Please list any significant family history________________

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What type of exercise do you do (if any)?______________

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Hours per week?____________________________
Are you a vegetarian?..□ yes □ no
What nutritional supplements do you take? ______________

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Women Only

Do you have painful periods ………………………..□ yes □ no
At what age did they begin to be painful?______________
Have you had any trauma to your pelvis…………..□ yes □ no
(eg. falls, terminations, operations, D&C physical violence)
Briefly describe ___________________________
Do you take the pill?..□ yes □ no
Are you pregnant?..□ yes □ no
If so, how many weeks________________________
When are you due to give birth?__________________
How many pregnancies have you had?_______________
Have you had a caesarian?.................................□ yes □ no
Did you have an episiotomy?...............................□ yes □ no
Did you tear?...□ yes □ no
Did you have an epidural?...................................□ yes □ no
Was the labour long or difficult?...........................□ yes □ no
Any problems with previous pregnancies?............□ yes □ no

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Did you have a difficult post natal period?.............□ yes □ no
Did you have difficulty becoming pregnant?...........□ yes □ no
Have you been through menopause?...................□ yes □ no
Do you take HRT?...□ yes □ no
Any other comments about your health? ______________

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I hereby consent to my information being stored electronically and acknowledge that my patient records must be kept for a minimum of 7 years from the date of my last visit and if I am under 18 years of age my records will be kept until my 25th birthday.
*I also **acknowledge** that this clinic has a **24 hour cancellation policy** that applies to all appointments and that failure to provide 24 hours notice when changing/cancelling or missing an appointment may result in a **$45 cancellation fee being charged.***

Name: ____________________________ *Signature:*____________________________