Michal Kapic, DOMP
Manual Osteopath
Certified Rolfer
www.active-therapy.ca

Active Therapy Osteopathy & Rolfing

Osteopathy & Rolfing Intake and Consent Form

Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone (H): _____ (Bus.): _____ (Cell) _____
E-mail: _____
Date of Birth: _____
Occupation: _____ Primary Complaint: _____
Height: _____Weight: _____ How did you find me?: _____

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.

Would you like your therapist to send a progress report regarding your treatment to your:

Family Doctor	❒ yes	❒ no
Referring Doctor/Practitioner	❒ yes	❒ no
Other Practitioner involved in your care	❒ yes	❒ no

If yes, please provide contact information below

_____

_____

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information please feel free to ask. Your written permission is required to release any information, unless required by law.

Primary Reason for first visit: _____
Describe your general health: _____
Are you receiving treatment from other health care professionals? ❒ yes ❒ no
If yes, please explain: _____

Have you ever experienced pain or injury to?

❒ Shoulders	❒ Hips	❒ Head	❒ Sacroiliac Joints
❒ Arms	❒ Legs	❒ Neck	❒ Pelvis
❒ Elbows	❒ Knees	❒ Mid Back	
❒ Hands	❒ Feet	❒ Lower back	

Briefly provide relevant details:

_____

_____

Circle and explain (dates, procedures, et.) in area below:

❒ yes ❒ no Have you ever been in a car accident?
❒ yes ❒ no Have you ever experienced a hard fall onto your back or buttocks?
❒ yes ❒ no Have you ever experienced a hard blow to your head or a concussion?
❒ yes ❒ no Have you ever had any Surgical procedure?
❒ yes ❒ no Do you have a pin, plate or screw in your body?
❒ yes ❒ no Do you have any children?

No. of Children _____ No. of C-Sections _____ Are you pregnant now? ❒ yes ❒ no

_____

_____

Current Medications: Reason for Taking Medication:

_____ _____
_____ _____
_____ _____

Do you at the present time experience:

❒ yes ❒ no Dizziness, weakness, fainting, vertigo, drop attacks or disorientation?
❒ yes ❒ no Disturbances of vision, speech co-ordination or balance, or difficulty swallowing?
❒ yes ❒ no Numbness or pins and needles in any part of your body?
Where? _____
❒ yes ❒ no Difficulty with bowel or bladder function?
❒ yes ❒ no Cough, shortness of breath, chest pain, or palpitations?
❒ yes ❒ no Poor appetite, nausea or vomiting?
❒ yes ❒ no Difficulty sleeping?
❒ yes ❒ no A significant weight change in the past year?

Have you ever experienced:

❒ yes ❒ no Recurrent ear, throat or sinus infections?
❒ yes ❒ no Respiratory disease or disorders? (i.e.: asthma, pneumonia, bronchitis, etc.)
❒ yes ❒ no Stomach, intestinal or any digestive problems?
❒ yes ❒ no Bladder or kidney problems? (i.e.: infection, disease, etc.)
❒ yes ❒ no Gynecological conditions? (i.e.: endometriosis, cysts, fibroids, etc.)
❒ yes ❒ no Have you ever consulted a physician for any of the above?

If yes, please explain: _____

_____

Do you have any of the following conditions? (please circle/check)

❒ Diabetes
❒ Cancer
❒ Tumor
❒ Allergies

_____
_____
_____
_____
_____
_____

❒ Heart Disease/Problems
❒ High/Low Blood Pressure
❒ Stroke/CVA
❒ Epilepsy (type

_____

❒ Asthma
❒ Migraines
❒ Headaches (type)

_____

❒ Hepatitis
❒ HIV/AIDS
❒ STD'S
❒ Tuberculosis
❒ Arthritis (type)

_____

❒ Skin Conditions
❒ Other

_____
_____

Mark the areas on the body where you feel the described sensations using the following marking:

Pain: XXXX

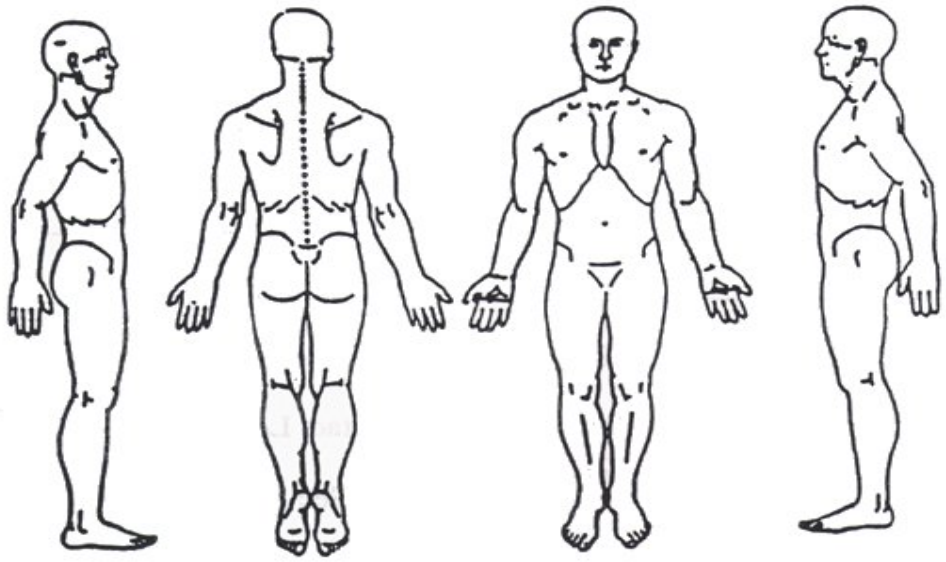
Burning: ////

Numbness: - - - - -

Tightness: IIIII

Pins/Needles: OOOO

Stabbing: **



FAMILY HISTORY: Please identify any problems listed above that have occurred in your immediate family.
(Indicate family members affected)

Ailment:	Affected:

CLIENT CONSENT TO ASSESSMENT/TREATMENT

Treatments may include manual therapies where the health practitioner places his/her hands on your body. Many techniques will involve contact between your body and the practitioner's body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones. If intraoral work is required, disposable latex or vinyl gloves will be worn.

At times, the practitioners may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The techniques can be discontinued or modified to be comfortable for you.

I agree that Michal Kapic, DOMP can collect, use and disclose my personal information and personal health information provided by me in this client health inquiry history form to provide me with the services I request and for the other limited purposes set out in privacy policy.

I hereby give my consent for treatment. I am also aware that Michal Kapic, DOMP will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered. I acknowledge that Michal Kapic, DOMP will not be responsible for any lost or stolen personal belongings.
I declare I will inform Michal Kapic, DOMP if there are any changes in my health history, upon my next visit.

I have been advised Michal Kapic, DOMP 24hr cancellation policy, and I authorize a full service charge should this be enforced.

DATE: _____ Signature: _____