Patient Details & Health History

Date: _____

west perth osteopathy
whole body health

We appreciate your patience in fully completing this confidential questionnaire and your information will be kept strictly private according to clinic policy. The information is necessary in assisting us to provide the best care and will not be divulged to any other person without your prior consent.

Name: _____ DOB: _____

Address: _____

Email: _____

Phone: (H) _____ (W) _____ (M) _____

Occupation: _____ GP name & location: _____

Marital status: _____ Children: _____

Are you claiming a Motor Vehicle Accident/Workers Comp/ Disability Pension/DVA? _____

How did you find out about West Perth Osteopathy?

□ Friend/relative, please specify: _____

□ Yellow Pages printed □ Yellow Pages online □ Our website □ Google

□ Natural Therapy Pages □ Signage □ Osteopathy Australia (OA)

□ Professional (eg. GP, Podiatrist), please specify: _____

Personal Health Information

What is your reason for attending the clinic? _____

_____

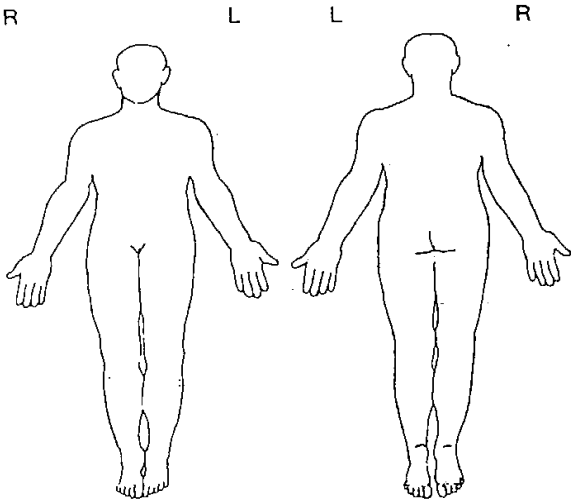
How have these problems interfered with your normal activities or work? _____

Have you had other treatment for these problems? □N □Y (if so from whom?) _____

Last seen & result of treatment? _____

Are you under the care of any other health practitioners? _____

Please indicate where your present symptoms are on the diagram below-



Please indicate the intensity of your pain on the scale:

None 1 2 3 4 5 6 7 8 9 10 Worst Ever

PAST & CURRENT MEDICAL HISTORY

Are you taking any medications and/or natural supplements? □ N □ Y (if yes, please specify): _____

_____

What accidents have you had in your lifetime (eg. car, work or sporting related), and when? _____

_____

What illnesses have you previously had in your lifetime, and when? _____

_____

Describe any surgery or hospitalisations you have had during your lifetime, and when: _____

_____

What x-rays, CT Scans or other medical imagery have been taken in your lifetime, and when? _____

_____

Exercise/Hobbies: _____

	Y	*N*	***Please explain details and dates if ticked YES***
Dietary/digestive issues eg. constipation, diarrhoea, reflux, IBS, food intolerances			
Heart/circulatory issues eg. varicose veins, high blood pressure, high cholesterol			
Respiratory, ear, nose & throat issues eg. asthma, sinus problems			
Nerve or muscle issues			
Mental health issues eg. depression, anxiety			
Female or male reproductive issues eg. PCOS, endometriosis, PMS			
Kidney, bladder, urinary issues			
Endocrine/hormonal issues eg. thyroid, diabetes			
Bone or Joint Problems			
Other			

Do you have trouble sleeping? □No □Yes (if so, please explain): _____

Do you use a dental splint? □No □Yes _____ Your Dentist? _____

Do you wear shoe inserts? □No □Yes _____ Your Podiatrist? _____

Does/has anyone in your immediate family suffer from *(please circle)*?:

☐ Arthritis ☐Heart Problems ☐Stroke ☐ Diabetes ☐ Cancer ☐ Epilepsy

How would you grade your physical health?

□ Excellent □Good □Fair □Poor □Getting Better □Getting Worse

Do you feel your energy/vitality could be better? □No □Yes (if so, please explain): _____

How would you grade your emotional/mental wellbeing?

□ Excellent □Good □Fair □Poor □Getting Better □Getting Worse

Are you pregnant? □No □Yes (how many weeks)? _____ Trying to fall Pregnant? □No □Yes

Do you Smoke? □No □Past □Yes (how often?)

_____

INFORMED CONSENT TO OSTEOPATHIC CARE

I hereby request and consent to Osteopathic treatment by any of the following Osteopaths, or any other Osteopath working in this clinic authorised by Ray Power.

- **Dr Ray Power**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Robert De Maio**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Joanne Olsen**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Laura Baldock**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Cybele Todd**
  BAppSc(Clinical), BOsteoSc
- **Dr Leanda Lintzen**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Kate Locke**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Sarahjane O'Leary**
  MOst
- **Dr Madeleine Goodman**
  BAppSc(Comp Med), MOst
- **Dr Allison Smith**
  BAppSc(Comp Med), MOst
- **Dr De-arne Bordin**
  BAppSc(Clinical), BOsteoSc

I have had the opportunity to discuss the nature and purpose of Osteopathic treatment with the Osteopath.

I understand that results are not guaranteed.

I understand, and am informed, that as in the practice of medicine, Osteopathy has some risks associated with treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, strokes and stroke-like episodes.

I do not expect the Osteopath to be able to anticipate and explain all risks and complications and I wish to rely on the Osteopath to exercise judgment during the course of treatment, which the Osteopath feels at the time, based upon the facts then known, is in my best interests.

I have read the above, and 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 other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

I _____ understand that the time I book with my practitioner/s
Patient's Name
is specifically reserved for me. Therefore **I must give 24 hours' notice to change/cancel appointments;**

otherwise a cancellation fee will be applied.

This enables us to offer your appointment to other patients who require treatment.

You will receive a courtesy reminder the day prior to your appointments.

☐ I do **not** wish to receive the (quarterly) Clinic Newsletter, with health news, updates and offers, or any other articles of interest, via email.

_____

Patient's Signature

_____

Date