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 Back 2 Basics Health care?

□ Craigieburn Advertiser □ Sign

□ Yellow Pages □ Internet □ Local Directory

□ Existing client at Back 2 Basics Health care

□ 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 next page

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

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

_____

_____

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 _____

_____

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

_____

Hours per week? _____
Are you a vegetarian?..... ☐ yes ☐ no
What nutritional supplements do you take? _____

_____

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

_____

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? _____

_____

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:* _____