Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Rehabilitative Manual Therapy Intake

Patient Information

Name_____Date_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-Mail_____

☐ Yes, sign me up for the monthly e-newsletter

Date of Birth *day*_____ *month*_____ *year*_____Age_____

Occupation_____

Referred By_____

Emergency Contact Information

Name_____Relation_____

Phone_____E-Mail_____

Reason for Treatment: _____

_____

_____

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Health History: Please circle all that apply to you.

Head:

- Headaches
- Dizziness
- Earaches
- Sinus problems
- Loss of smell/taste
- Vertigo
- Hearing Loss
- Vision problems/Loss
- Memory Loss
- Fatigue
- Sleep disorder

Digestion:

- Poor digestion
- IBS
- Constipation
- Diarrhea
- Crohn's Disease
- Diabetes
- Liver/Gallbladder

Respiratory /Cardiovascular:

- Chest pains
- Pacemaker
- Chronic cough
- Shortness of breath
- Asthma
- Bronchitis
- Emphysema
- Heart Disease
- Blood pressure high/low
- Anaemia
- Deep vein thromb.
- Varicose veins
- Poor circulation
- Heart palpitations
- Stroke
- Cold Hands/Feet
- Liver/Gallbladder

Muscle/Joints:

- Muscle and Joint pain
- Swollen or Stiff joints
- Neck or Shoulder pain
- Back pain (Lower/Middle/Upper)
- Jaw pain
- Rheumatoid arthritis
- Osteoarthritis
- Coldness/Numbness (Arms/Legs)
- Artificial joints, pins, wires

Skin:

- Sensitive skin/Rashes
- Eczema/Psoriasis

Reproductive/Urinary:

- Reproductive
- Kidney/Bladder

Other:

- Thyroid
- Spleen
- HIV/AIDS
- TB
- Hepatitis
- Hormone imbalance
- Cancer

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Exercise: Excessive / Regular / Occasional / Little / None

Diet: Regular meals / Irregular eating habits / Regular alcohol usage / Recreational drug use

Previous care: Osteopathy / Massage Therapy / Chiropractic / Physiotherapy / Naturopath / Homeopath

Other: _____

Allergies: _____

_____

Social History: Tobacco / Coffee / Drugs / Alcohol / Other

Family Medical History: _____

_____

Women

Menstruation – Painful /Heavy / Light / Normal / Irregular / Absent / Pregnant

Number of children: ____ Menopause: Pre / Active / Post Breast Tissue: Cystic / Tender / Other

Current prescriptions medications (including herbal or naturopathic products):

_____

_____

Previous medical history (traumas and injuries):

Date of accident or surgery_____

Description: _____

_____

_____

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Date of accident or surgery_____

Description: _____

_____

_____

Date of accident or surgery_____

Description: _____

_____

_____

Is there any other additional information necessary for your health status?

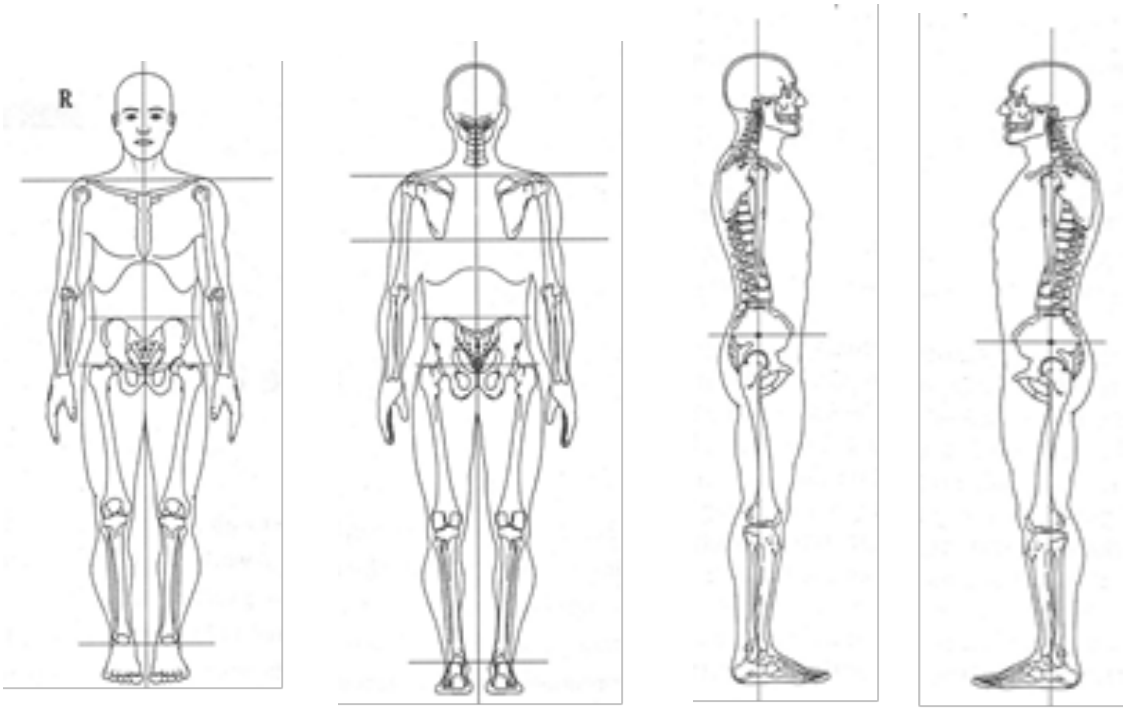
_____

_____

_____

_____

Please use the diagrams to indicate any areas of discomfort.



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Patient/Client Agreement Form

Each patient/client is required to read the following before treatment.
Your signature below acknowledges the following:

I, the undersigned, wish to participate in manual therapy sessions ("Sessions") run by Arianne Gosselin, a STUDENT of the Canadian Academy of Osteopathy (CAO). As a condition to my participation in the Sessions, I hereby signify that:

1. I understand that the Sessions are offered to support healing and do not constitute an effective substitute for the medical treatment of illness, injury, or any other medical condition. I will consult my regular physician(s) prior to engaging in the Session(s) in which I am participating and will continue to consult with my physician(s) during such Sessions regarding my health and any medical treatment that I may require. In signing this document, I am giving full consent to the manual therapy for this Session and any Sessions that may follow in the future.
2. I understand that Arianne Gosselin is not functioning as a physician, nurse, emergency medical technician, Osteopath, OR Osteopathic Manual Therapist and by making the Sessions available, is not undertaking any responsibility regarding my medical condition(s). If my medical condition should change, I understand that it is my responsibility to discontinue the Sessions and to immediately consult with my physician about continuing or resuming participation in the Sessions.
3. I agree that I am responsible for deciding whether to participate in the Sessions, and I have not relied on the advice of any other person, in doing so. I have had the opportunity to ask questions about the Sessions and this Consent, Waiver and Release, and have received answers to my satisfaction. I understand the risk involved in participating in the Sessions, including potential risk of physical injury. I agree to assume all risks associated with participating in the Sessions and agree to assume full responsibility for any injuries, losses, or other damages that I may suffer as the result of my participation in the Sessions.
4. I understand that all of the information recorded on the health history form is essential to give the most effective and safest treatment. In signing this form, it is understood that everything recorded is strictly confidential and no information may be released or discussed with anyone without your written consent. I consent that all of the information provided is accurate and up-to-date. I understand that it is necessary to notify my therapist of any changes to my medical history before treatment. I have discussed the nature of the treatment and consent to treatment as described by my therapist.
5. I understand that Arianne Gosselin is a student of the CAO and cannot bill insurance companies, write receipts to be used to bill insurance companies, used as a medical expense, government or otherwise. I understand that Arianne Gosselin does not participate in WSIB or MVA claims. I understand payments are to be made in either cheque or cash form and that payment is due upon completion of the Session.
6. I understand that I am to arrive 10-15 minutes prior to my scheduled Session appointment. In the case of late arrivals, I fully understand that only the time remaining for my appointment will be allotted at the discretion of the therapist. I understand that if I am unable to make my scheduled Session appointment, I will provide 24 hours notice so that other may receive treatment in my place. I understand that missed appointments without notice will be issued a full charge of the time scheduled, exception the event of severe illness or family

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emergency. I understand that correspondence with Arianne Gosselin will be in the form e-mail (preferred) or, in immediate cases, telephone (no text messages).

7. I understand that prior to my Session I will not wear perfume/cologne as others may suffer from severe allergies or are sensitive to scents. Because of the nature of Osteopathy, I will wear appropriate clothing, such as shorts and a t-shirt, that is loose and comfortable.
8. I hereby release, indemnify and hold harmless Arianne Gosselin and her directors, officers, parents, subsidiaries, affiliates, and agents from any and all claims, demands, personal injuries, costs, or expense (including attorney`s fee) arising from or relating in any way to my participation in the Sessions.
9. I understand that, if I am under the age of 18, I must have a parent or legal guardian accompanying me for all Sessions. Should treatment continue past my 18th birthday I have the option to continue with this accompaniment or proceed individually.
10. I have read this Consent, Waiver and Release or have had it read to me, if necessary, and I fully understand its contents. In signing this document I agree to all the terms and policies outlined and have disclosed all information throughout the health history form that could possibly have an effect on the outcome of my health. I am voluntarily executing this Consent, Waiver and Release.

I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by me, unless the law requires it.
I understand that I may look at my medical records at any time, and can request a copy of this record by paying the appropriate fee.
I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.
I understand that the practitioner will answer any questions that I may have to the best of her ability.
I understand that results cannot be guaranteed.
I do not expect the therapist to be able to anticipate and explain all risks and complications.
I will rely on the therapist to exercise her judgment during the course of the procedure which she feels at the time is in my best interest, based on the facts then known.
With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above.
I intend this consent form to cover the entire course of treatment for my present condition.
I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time.
I understand if I am seeing more than one practitioner at the Ottawa Integrative Health Centre I imply consent for them to share and discuss my file and deemed necessary by the practitioners.

Patient name_____

Patient Signature_____Date_____

*Ottawa Integrative Health Centre care provider:*_____