Candace Kakowchyk Osteopathy Medical History Intake Form

610-1125 Howe Street
Vancouver, BC
V6Z 2K8

778.814.3124

PLEASE COMPLETE THIS FORM IN FULL. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Date:_____ **Email:**_____

Name:_____ **Age:** ___ **Date of Birth:**_____

Home Address: _____

Province: _____ **Postal Code:** _____ **Occupation:** _____

Home Phone #: _____ **Business/Cell Phone #:** _____

General Practitioner: _____ **Address:** _____ **Phone #:** _____

Date of Last Medical Exam: _____ **Referred By:** _____

What is your main complaint? _____

_____

_____

Are you currently undergoing any forms of treatment? Please detail.

_____

_____

Please list ALL of your medications & supplements:

_____

_____

Past Surgeries, including Dates:

_____

_____

Past Injuries/Accidents, including dates:

_____

_____

Are you pregnant? _____ **If Yes, what trimester? _____**

Number of Children: _____ **Complications with Pregnancy? _____**

Complications with Labour & Delivery? _____

Do you have any surgical implants, such as artificial joints, pins, needles, metal plates, pacemaker, other? If yes, where?

_____

_____

How would you describe your present state of health? _____

_____

PLEASE CHECK ANY PAST, OR CURRENT, HEALTH PROBLEMS

Digestive System:	Gynecological/Urological System:	Cardiovascular System:
☐ Heart Burn ☐ GERD ☐ Ulcers (Location: _____ _____) ☐ Gas/Bloating ☐ Nausea ☐ Appetite Changes ☐ Food Allergies ☐ Hemorrhoids ☐ Gallstones ☐ Diarrhea ☐ Constipation ☐ IBS ☐ Celiac Disease ☐ Chron's or Colitis	**Women:** ☐ Painful/Irregular Menstruation ☐ Fibroids/Uterine Cysts ☐ Endometriosis ☐ IUD ☐ Menopause ☐ Loss of Pregnancy ☐ Herpes/STDs **Men:** ☐ Prostatitis ☐ Sexual Dysfunction ☐ Herpes/STDs ☐ Other: _____	☐ Blood Clots ☐ Varicose Veins ☐ Chest Pain/Cramps ☐ Angina ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Arrhythmia ☐ Heart Attack ☐ Heart Palpitations ☐ Numbness ☐ Cold Hands/Feet ☐ CVA/Stroke/Aneurysm ☐ Hemophilia ☐ Congestive Heart Failure

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Respiratory System:	Nervous System:	Musculoskeletal System:
☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Emphysema ☐ Allergies ☐ Cold/Flu ☐ Shortness of Breath ☐ COPD ☐ Pulmonary Embolism ☐ Pulmonary Edema ☐ Tuberculosis ☐ Other: _____	☐ Epilepsy ☐ Headaches ☐ Migraines ☐ Dizziness ☐ Vertigo ☐ Fainting ☐ Balance Problems ☐ Neuralgia ☐ Paralysis ☐ Parkinson's ☐ Neuritis ☐ Other: _____	☐ Muscle/Joint Pain (Location: _____) ☐ Bursitis ☐ Tendonitis ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Dislocation ☐ Muscle/Joint Strain ☐ Weakness/Loss of Strength ☐ Clumsiness ☐ Other: _____
Immune System:	**Urinary System:**	**Ears/Nose/Throat/Eyes:**
☐ Systemic Lupus Erythematosus ☐ Edema ☐ HIV/AIDS ☐ Swollen Lymph Nodes ☐ Autoimmune Disease (Type:_____) ☐ Other: _____	☐ Urinary Tract Infection ☐ Painful Urination ☐ Frequent Urination ☐ Nighttime Urination ☐ Kidney Stones ☐ Kidney Failure ☐ Incontinence ☐ Ptosis of Bladder ☐ Polycystic Kidney Disease ☐ Other: _____	☐ Sinusitis/Sinus Infection ☐ Ear Infection ☐ Tonsillitis/Strep Throat ☐ Tinnitus/Hearing Loss ☐ Near/Far Sighted ☐ Astigmatism ☐ Glaucoma ☐ Fillings/Root Canals ☐ Tooth Extractions ☐ Orthodontic Work ☐ Dental Implants
Integumentary System:	**Endocrine System:**	**Other:**
☐ Scleroderma ☐ Acne ☐ Herpes/Cold Sores ☐ Dermatitis ☐ Eczema ☐ Psoriasis	☐ Pancreatic Disorder ☐ Pituitary Disorder ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Pineal Gland Disorders ☐ Depression	☐ Osteoporosis ☐ Cancer (Type:_____) ☐ Undiagnosed Lump ☐ Hernia (Type:_____) ☐ Other: _____ _____

I Certify the Information Provided in this Form is True and Accurately Reflects My Past, and Present, Health Status.

_____ _____

Patient (or Guardian) Signature **Date**

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Consent to Assessment and Treatment

I _____ consent to assessment, and treatment, for my present complaint. I understand I have been asked to wear loose fitting clothing for purposes of this assessment and/or treatment.

I further understand I may stop assessment and/or treatment at any time, and for any reason.

My practitioner has provided me with all relevant information to the treatment and I understand the benefits, risks and side effects of this treatment plan. I have also been provided, and understand, alternative courses of treatment where applicable. All of my questions regarding all aspects of the assessment, treatment and treatment plan, have been addressed and answered.

_____ _____

Patient Signature Date

Cancellation Policy

I, _____, agree to give **48 business hours notice** when cancelling appointments and understand the **full treatment fee applies for all appointments cancelled.**

Receipts issued for missed appointments will state **Missed Appointment**, and further appointments will not be scheduled until payment is received.

_____ _____

Patient Signature Date

Privacy Policy

I understand all information collected on this form is for the sole purpose and use of my practitioner, and is collected in accordance with the Personal Health Information Protection Act (PHIPA, 2004) and the Personal Information Protection and Electronic Documents Act (PIPEDA, 2000). My name, address, email and phone number are collected in order for my practitioner to contact me regarding any appointment changes, payment inquiries, or news and changes applicable to the clinic. They will not be solicited or sold to any outside source.

I understand my practitioner will not, under any condition, supply my insurer, doctor, or anyone else, with my confidential medical and treatment history without first receiving my express written consent. The same applies if my practitioner requires permission to contact my doctor in the event more details are needed in order to treat my present condition.

_____ _____

Patient Signature Date

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