Spine Align Osteopathy

Petula Jennings, RMO

Reg. # RMO 01168

Patient Intake Form

Please fill out these forms to the best of your knowledge.

Full Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: Home _____ Work _____ Cell: _____
Email: _____
Date of birth: _____ Gender: _____
Occupation: _____
Primary Physician: _____ Phone #: _____

Other Health Practitioners that you are seeing:

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____

How did you hear about us?

Doctor___ Other Health Practitioners___ Website___ Signage___ Word of Mouth____

Other: _____

This is a confidential record of your medical history and will be kept in this office. Information contained here in will not be released to any persons, unless by your permission.

The Information in the following forms will assist us in treating you in the safest and most efficient way possible. If you have any questions concerning the requested information, please feel free to consult us. Your written permission is required to release any information; unless required, by law.

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Health and Lifestyle Information

What is your main health concern?

_____
_____
_____

Please list any other health concerns in order of importance, such as: Physical, Emotional, Mental, etc.

1. _____
2. _____
3. _____
4. _____

Please list any restrictions and/allergies.

_____
_____

How much water do you drink per day? _____

How many and what type of alcoholic beverages do you consume per week?

_____
_____

Do you smoke? Yes ___No ___ How many cigarettes daily? _____

On average, how many hours do you sleep at night? _____

Do you have trouble falling asleep at night? _____

Do you wake up during the night? Yes___No ___ Any specific time or reason?

_____

Do you exercise regularly? Yes ___ No ___

What type of exercise and how often?

_____
_____

Have you ever experienced pain or injury? _____

Shoulders _____ Hips _____ Head _____ Sacroiliac _____ Arms _____ Legs _____

Neck _____ Pelvis _____ Elbows ____ Knees _____ Mid-Back _____

Hands _____ Feet _____ Lower back _____

Briefly provide relevant details:

_____
_____
_____

Health History:

Circle yes or no, and explain, (dates, procedures, etc.) in the space below.

Have you ever been in a car accident? **Yes __ No __**

Have you ever experienced a hard fall onto your hands or buttocks? **Yes __ No __**

Have you ever experienced a concussion or other head injury? **Yes __ No __**

Have you ever had any surgical procedure? **Yes __ No __**

List current Medication (*reasons for taking them*):

_____
_____
_____

List Supplements/Herbal Medicines (*reason for taking them*):

_____
_____
_____

Do you at the present time experience: (*If yes, please circle the related one* s)
Yes ____No____

Dizziness, weakness, fainting, vertigo, drop attack, or difficulty with bowel or bladder functions? Yes _____ No _____

Do you have any Bladder or Kidney problems? (ie. Infection, Disease, etc.)
Yes _____ No _____

Do you have any Stomach, Intestinal or any digestive problems? Yes____No ____

Poor appetite, Nausea or Vomiting? Yes ____ No _____

Do you have any numbness or pins and needles in any part of your body?
Yes_____No_____

(If yes, please explain).

_____

_____

Do you have any Respiratory disease or disorder? (ie. Asthma, Pneumonia, bronchitis) Yes _____No _____

Cough, Shortness of breath, chest pain, or Palpitations? Yes _____ No _____

(If yes, please explain)

_____

_____

Any significant weight changes in the past year? Yes ____ No ____

Do you have any of the following conditions? (*Please circle yes or no.*)

Carpal Tunnel Syndrome **Yes___No___** Diabetes (Type 1 or Type 2) **Yes___No ___**

Tumor(s) Cancer(s) **Yes___No___** Heart disease or problems **Yes___No ___**

Allergies or Intolerances **Yes___No ___** High or Low blood pressure **Yes___No ___**

Epilepsy (Grand Mal or Petite Mal) **Yes___No___** Fibromyalgia **Yes___No ___**

Seizures **Yes ___ No___**

Migraines **Yes ___ No ___** (What type) _____ Anxiety **Yes___No___**

Headache **Yes ___ No ___** (Type) _____ Osteoporosis **Yes___No___**

Herniated disk **Yes ___No ___** Scoliosis **Yes___No___**

Arthritis **Yes ___ No ___** (Type) _____ Hepatitis **Yes___No___**

TMJ **Yes ___ No ___** Muscle strain **Yes ___No ___**

Whiplash **Yes ___ No ___** (*Reason*) _____

Tendon Strain **Yes ___ No ___**

Any skin conditions **Yes ___ No ___**(If yes, explain) _____

_____

_____

Are there any other conditions? _____

_____

_____

Have you ever consulted a Physician for any of the above conditions? Yes___ No__

Women's Health

Are you currently pregnant? **Yes ___ No ___**

Is your period regular**?** **Yes ___ No ___**

Do you experience low back pain? **Yes ___ No ___**

Is your period painful? **Yes ___ No ___**

Length of monthly cycle (Number of days) _____

Average length of Period and flow (in days)

_____

_____

Do you have any Gynecological conditions? (Endometriosis, Fibroids, Polyps, polycystic ovarian syndrome etc.) **Yes ____ No ____**

(*Please explain)*

_____

_____

Men's Health

Do you have regular screening test done (blood work, prostate examination)?
Yes ___No ___

Do you feel any burning or pain while urinating? Yes __ No _

How many times do you wake up in the night to use the bathroom?

_____

_____