Mahmood Mohseni DOMP

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INITIAL OSTEOPATHIC

INTAKE & CONSENT FORM

Date: _____

Name: _____ Email: _____

Address_____

Phone (c) _____(h)_____(w)_____

Occupation_____

Preferred method of contact: ☐ Email ☐ Phone Call

Birth date: _____

Family Doctor:_____

Emergency Contact: _____

Relationship & Phone number: _____

General Health Questions : (Yes or No)

Do you sleep well?

Do you exercise regularly?

Do you eat regularly?

Do you drink water regularly?

Do you smoke?

Do you drink alcohol?

Do you drink coffee? If yes, how much?

_____

What is your ***Primary Concern*** today? :

_____

_____

Have you had any Traumas /Accidents/Injuries that may have contributed to these concerns?

_____

_____

Have you had imaging of any of these concerns?

_____

_____

Hospitalization/Surgeries: (please include dates/reasons)

_____

_____

_____

Medications and Current Supplements: _____

_____

_____

_____

Are you Current involved in other Healthcare/ Therapies:

- ☐ Chiropractic
- ☐ Massage Therapy
- ☐ Physiotherapy
- ☐ Naturopathic Dr

Please check all conditions that you have experienced:

<u>Joint/Soft Tissue</u>

☐ Neck pain ☐ Shoulder pain ☐Jaw pain ☐ Numbness or tingling down the arms ☐Spondylolisthesis

☐Scoliosis ☐low back Pain ☐acute muscle joint pain ☐ muscle spasms

☐ Knee pain ☐ hip pain ☐ foot or ankle problems ☐ upper/mid back pain

☐ Pelvic / SI joint pain ☐ Degenerative discs ☐ osteoarthritis ☐ rheumatoid arthritis

☐ Paralysis

<u>Cardiovascular/Respiratory</u>

☐ High blood pressure ☐ low blood pressure ☐ heart attack ☐ pace maker ☐ palpitations ☐ stroke

☐ varicose veins ☐ swelling of ankles ☐ heart murmur ☐ coronary heart disease ☐ migraines

☐ Headaches ☐ poor circulation☐ Chronic sinus ☐ Bronchitis ☐ strep throat ☐ asthma ☐ COPD

☐ Difficulty breathing ☐ Dizziness ☐ Pneumonia ☐ fainting

Reproductive (Fem)

☐ Painful menstruation ☐ irregular cycle ☐ nervousness ☐ sudden weight gain ☐ painful breast tissue ☐ Bladder leakage ☐ fatigue ☐ peri-menopause ☐ menopause ☐ hysterectomy full ☐ partial

Of pregnancies _____

Digestive Other

☐ Rashes ☐ Hepatitis ☐ Swollen Glands ☐ Poor Appetite ☐ Allergies ☐ bloating ☐ gas

☐ Constipation/slow ☐ Athletes foot ☐ nausea ☐Gall stones ☐Kidney stones ☐Hiatal hernia

☐ulcers ☐IBS ☐Colitis ☐Crohn's disease ☐Cirrhosis

Mental Health

☐anxiety ☐depression ☐Bipolar disorder ☐OCD ☐Substance abuse ☐ADD/ ADHD

Immune / Lymphatic

☐Edema ☐Lymphedema ☐Autoimmune Disorders☐

Head / ENT ☐Dizziness ☐Migraines ☐Loss of vision ☐Tinnitus ☐loss of smell /taste

Do you have any internal pins, wires, artificial joints or Special equipment?

(If yes, please specify)

_____
_____
_____

Anything else you would like to disclose or address?

_____
_____
_____
_____

PLEASE READ CAREFULLY AND SIGN BELOW:

Consent to Treatment and Cancellation policy

1. All patients are required to fill out an initial intake form to the best of their knowledge. This is for the patient and practitioner safety and kept completely confidential.
2. 2. All patients should wear moveable clothing such as gym T-SHIRT (NO TANK TOPS) and yoga pants or sweat pants. No shorts. Ladies will refrain from wearing dresses or skirts. You are more than welcome to bring appropriate clothing to change into when you arrive for your appointment. All patients must be wearing socks for treatment.
3. All patients will arrive 5 minutes prior to scheduled apt times. If you arrive late, you will only receive the time that is remaining.
4. As the practitioner I will be on time for your appointments and will give you sufficient notice of sick days and emergencies and will make your rescheduling a priority.
5. Anyone who has any serious medical diagnosis or recent surgeries must obtain written consent from their doctor / surgeon before I will proceed with treatment.
6. I cannot treat women in their first trimester of pregnancy or individuals in stages 1 or 2 of a cancer diagnosis.
7. It is my right as a practitioner to determine if you are safe for treatment and to terminate at any time if I feel it necessary
8. It is your right as the patient to stop treatment at any time for any reason.
9. Minors must be accompanied by a parent or guardian at all times
10. If you are coming in for an acute condition I will charge for only one treatment per week as I may require you to come back several times to treat the condition. I will charge again after 7 days

Cancellation Policy

Your appointment time reserved for you. A late cancelation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hrs notice for any cancellations or changes to your appointment. Patients who provide less than 24hrs notice or miss their appointment will be charged a cancellation fee.

☐I am aware of the cancellation policy **Initial:**_____

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented about. In addition, I authorize the clinic and its associated professionals to communicate with my family Dr and or referring Dr / Professional as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third partied with my permission.

☐ I agree **Initial:**_____

NAME (Print)_____

SIGNATURE:_____

DATE:_____