WHRIA
Women's Health & Research
INSTITUTE OF AUSTRALIA

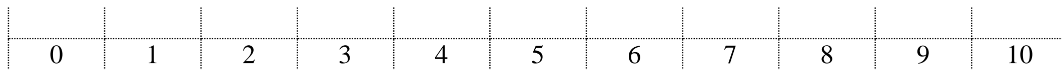
OSTEOPATHY FORM

FIRST NAME		SURNAME	
DATE OF BIRTH	___ ___ / ___ ___ / ___ ___ ___ ___	PHONE NO.	

WHAT IS THE MAIN PURPOSE OF YOUR VISIT TODAY?

WHEN DID YOUR PROBLEM BEGIN AND WAS IT RELATED TO A SPECIFIC INCIDENT?

HOW WOULD YOU RATE YOUR PAIN USING THE FOLLOWING SCALE?



0	1	2	3	4	5	6	7	8	9	10

No Pain *Moderate Pain* *Worst Possible Pain*

HAVE THERE BEEN ANY TESTS/SCANS/X-RAYS FOR THIS COMPLAINT?

HAS ANY OTHER TREATMENT BEEN SOUGHT FOR THIS COMPLAINT?

PLEASE LIST ANY CURRENT MEDICATIONS (Including over the counter medications and vitamins/supplements):

DO YOU HAVE ANY MEDICAL CONDITONS? IF YES, PLEASE OUTLINE:

HAVE YOU HAD ANY TRAUMA IN THE PAST INCLUDING MOTOR VEHICLE ACCIDENTS, FALLS, FRACTURES OR SPRAINS? IF YES, PLEASE PROVIDE DETAILS.

HAVE YOU HAD ANY SURGERIES OR HOSPITALISATIONS? IF YES, PLEASE PROVIDE DETAILS:

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS OR DIAGNOSES? Please tick all that apply.

□ Cancer
□ Heart Disease
□ High Blood Pressure
□ Stroke or TIA
□ Thrombosis/blood clots
□ Circulation problems
□ Thyroid disease
□ Dizziness/Vertigo
□ Diabetes
□ Liver disease/hepatitis
□ Epilepsy/seizures
□ Allergies (list below)
□ Multiple sclerosis
□ Migraine/headaches
□ Anaemia
□ Depression/anxiety
□ Smoking history
□ Alcoholism/drug problem
□ Asthma
□ Emphysema/chronic bronchitis
□ Irritable Bowel Syndrome
□ Bowel problems
□ Kidney disease
□ Urinary infections
□ Incontinence
□ Childhood bladder problems
□ Sexually transmitted disease
□ Physical or Sexual abuse
□ Chronic fatigue syndrome
□ Fibromyalgia
□ Arthritic conditions
□ Vision/eye problems
□ Hearing loss/problems
□ Osteoporosis
□ Eczema/dermatitis

Other:

PLEASE LIST ANY SIGNIFICANT FAMILY HISTORY:

WHAT TYPE OF EXERCISE DO YOU DO AND HOW OFTEN?

HOW WOULD YOU RATE YOUR CURRENT HEALTH ON A 0-10 SCALE WITH 10 BEING THE BEST? ……../ 10

HOW WOULD YOU RATE YOUR QUALITY OF SLEEP ON A 0-10 SCALE WITH 10 BEING THE BEST? ……../ 10

ANY ADDITIONAL COMMENTS ABOUT YOUR GENERAL HEALTH:

PLEASE READ CAREFULLY AND SIGN

To the best of my knowledge the above information is correct and should my medical situation change, I will inform the practitioner. I consent that if I am unable to give 24 hours' notice of cancellation, I will incur a late cancellation fee.

Signature____

Date____