Sheryl Crotta BA, M.OMSc., DOMRO (Osteopathic Manual Therapist)
55 Kent St. S., Simcoe, ON N3Y 2X9
www.simcoeosteopathy.com Phone: 519-426-4275

Please complete this Health History form as accurately as possible. These four pages will help to ensure that you receive safe and effective treatment. If at any time your health status changes, please let me know as soon as possible prior to your treatment. All information is strictly confidential and cannot be released to anyone without your written consent. If at any time you have any questions, please feel free to ask.

Name: ____

Address: ____

City: ____________________________Postal Code: __________________

Phone (H)________________(W)_______________Cell _________________

Email : ____

Age_________ Date of Birth: _______________Ht:________Wt:___________

Occupation: ____

Family Physician: ____________________________Phone_______________

Physician's Address:____

Reason for Treatment: ____

How/Where did you hear about this clinic?____________________________

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Head and Neck

_____ Headache
Type________________
_____Dizziness
_____Earaches
_____Sinus

Muscle & Joint

_____Pain
_____Stiffness
_____Swelling
_____Limited Motion
_____Fatigue
_____Osteoarthritis
_____Rheumatoid Arthritis
_____Back Pain
Upper___Mid___Lwr___
_____Shoulder Pain

Women

Menstruation
___Painful
___Heavy
___Light
___Normal
___Irregular
___Absent
___Pregnant
___Children#_____
___Menopause
___Hysterectomy

Respiratory

_____Chronic Cough
_____Shortness of Breath
_____Asthma
_____Bronchitis
_____Emphysema

Skin

_____Sensitive Skin
_____Rashes
_____Acne
_____Cold Sores
_____Bruise Easily
_____Varicose Veins
_____Deep Vein Thrombosis
_____Eczema/Psoriasis
_____Recent Tattoos
_____Recent Piercing
_____Recent Stitches

Cardiovascular

_____High Blood Pressure
_____Low Blood Pressure
_____Poor Circulation
_____Heart Surgery
_____Heart Disease
_____Pacemaker
_____Stroke

Digestive

_____Poor Digestion
_____IBS
_____Diarrhea
_____Constipation
_____Difficult Digestion
_____Liver/Gallbladder
_____Kidney/Bladder

Other

_____Other
_____Vision Problems
_____Vision Loss
_____Vertigo
_____Hearing Loss
_____Ear (infection/tubes)
_____Hepatitis Type_____
_____HIV ____TB

General Health Status

_____Good
_____Average
_____Poor

General Stress Levels

_____High
_____Moderate
_____Low

Diet

_____Regular Meals
__Irregular Eating
_____Caffeine
____Smoke
Pkg(s)/day______

Exercise

_____Regular
_____Occasional
_____Little
_____None

Previous Health Care

_____Massage Therapy
_____Chiropractic
_____Physiotherapy
_____Acupuncture
_____Osteopathy
_____Psychotherapy

____

Date of last full physical
____

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Allergies____
____

Current prescription medications and reason for use

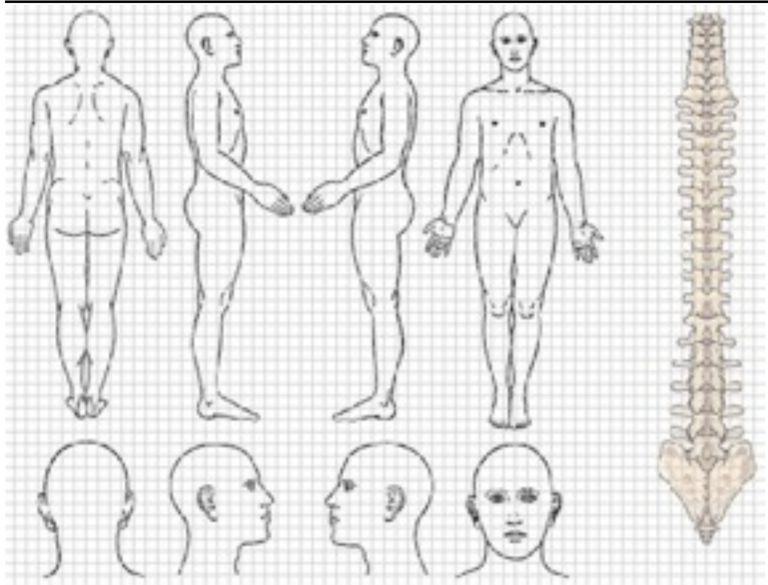
____
____
____

Date of accident or surgery:____________ Date of accident or surgery:______________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Date of accident or surgery: ___________ Date of accident or surgery: _____________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Of Special Note: (Pins, Wires, Prosthetics, Walker, Cane etc.)

____
____



Using these diagrams circle any areas of discomfort

Please use this area for any additional information or details_______________________
____
____
____
____
____

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Client Agreement

This form has been outlined so that you fully understand the office policies pertaining to this clinic. It is advisable that you fully read this form. If you have any questions, please ask prior to signing. Thank you.

1. All information recorded on the health history form is essential to providing you the most effective and safe treatment possible. In signing this form you understand that everything discussed and/or recorded is **strictly confidential** and no information may be released or discussed with anyone without your consent (see privacy policy).

2. As a Patient/Client, it is necessary to have a full assessment performed this is required for so that a relevant, safe, effective treatment plan can be set up for you. New health history forms must be revised after a long duration away from treatment, when seeing a new therapist for the first time or if your health status changes dramatically. The assessment is part of the initial treatment and may take up to the first half hour of the session. A new health history form must be completed and a re-assessment must take place each year to ensure all information is current.

3. Payment can be made in cash, cheque, credit or debit and a receipt will be issued to you following treatment, cheques returned **(NSF) will be subject to a service fee of $35.**

4. **Fees:**
Initial Assessment & Treatment Session: **Adult:$80 Youth:$70 Child 12 & under:$60**
Follow up Treatment Session: Adult: **$60 Youth: $50 Child 12 & under: $40**

5. **Missed appointments without 24 hours notice** will be issued a $35 cancellation fee for the missed scheduled appointment **except** in the event of family emergency or illness.

6. Please arrive 5 minutes prior to your scheduled appointment time.
In case of **late arrivals,** it is fully understood that only the time remaining for your scheduled treatment will be.

7. **It is not my policy to work through WSIB or MVA (motor vehicle accidents) claims**; In the event you do require a therapist that does work with these types of claims, a new therapist in the area will be suggested to you.

8. Patients/Clients under the age of 16 must have parent or legal guardian accompanying them for the initial assessment / follow up visits and must co-sign this agreement.

Name: ____

Signature: ____

Signature of parent or guardian (if required): ______________________________

Date: __________________________

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Health Consent Form: The Armstrong Clinic for Integrative Medicine requests your informed consent to receive Osteopathic Manual Therapy. It is required that you understand the services provided to you, the cost involved and what we do with the personal information we obtain from you.

Schedule of Fees and Services:

INITIAL ASSESSMENT & TREATMENT SESSION

Adults..........................$80
Youth 13-17 years old...$70
Children 12 and under.....$60

FOLLOW-UP TREATMENT SESSION

Adult...............................$60
Youth 13 - 17 years old......$50
Children 12 and under $40

I understand the assessment and treatment as explained to me and understand that I may verbally withdraw my consent at any time.
It is understood that agents (i.e. reception staff or clinic associates) may need to contact me in order to advise me of changes to my scheduled appointments (s) and or relay a message to me from my Therapist.

It is acknowledged that a message may be left on voice mail/answering machine or by e-mail in order to advise me of relevant information regarding my appointment(s).   With my signature, I provide my consent to agents of the Armstrong Clinic for Integrative Medicine to contact and leave messages or email form me regarding my appointment(s).

If I have agreed to receive treatment by another practitioner at the Armstrong Clinic for Integrative Medicine, it is agreed that my file may be available to them with subsequent verbal or signed consent.

I acknowledge that in the case of missed appointments or inadequate cancellation time (i.e. 24hrs), a fee of $35 will be invoiced to be paid by myself.

Name (please print): ____

Signature: _________________________________ Date:_______________