**NEW PATIENT FORM**

**Welcome to B enhanced Osteopathic Clinic**

**Please read and complete this form carefully.**

**This information completed on this form is strictly confidential.**

**PERSONAL DETAILS**

Date…../…../…..

Title…….Name ……………………………. Date of Birth…..........................................

Height in cm………………………………... Weight in kg………………………………...

Pregnant (include stage)…………………. Occupation………………………………….

Address……………………………………… ………………………….……………………

……………………….Postcode…………….. Email………………………………………...

Phone Mobile……………………………….. Emergency contact………………………...

Home………………………………... Emergency number………………………..

GP’s name…………………………………… How did you hear about us?

GP’s phone number………………………… ………………………………………………..

GP’s address………………………………… Recommended by…………………………..

………………………………………………… Do you have private health insurance?

Medicare number…………………………… Yes No Name …………………………….

DVA/Pension/Concession number Do you have an EPC form Yes No

……………………………………………….. How many sessions have you used?…....

How do you prefer to be reminded of your future appointments? SMS EMAIL

Are you claiming a Motor Vehicle Accident/ Workers Compensation? Yes No

Claim No…………………………………….. Insurer………………………………………

Date of injury………………………………... Case manager………………………………

**HEALTH HISTORY**

**Past treatments and results**

Have you been to an Osteopath previously? Yes No

Other similar to Osteopath (please specify) …………………………………………………………………………………………………………………

What conditions did you see them for, when and results treatment?

|  |  |  |  |
| --- | --- | --- | --- |
| What condition was it for? | Who did you see e.g. Osteopath, Physio or Chiro | When did you see them? | Results of each treatment |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

How many sessions have you had with them?.................................................................................

………………………………………………………………………………………………………………….

**Today’s visit**

What is the main purpose of the visit today?...................................................................................

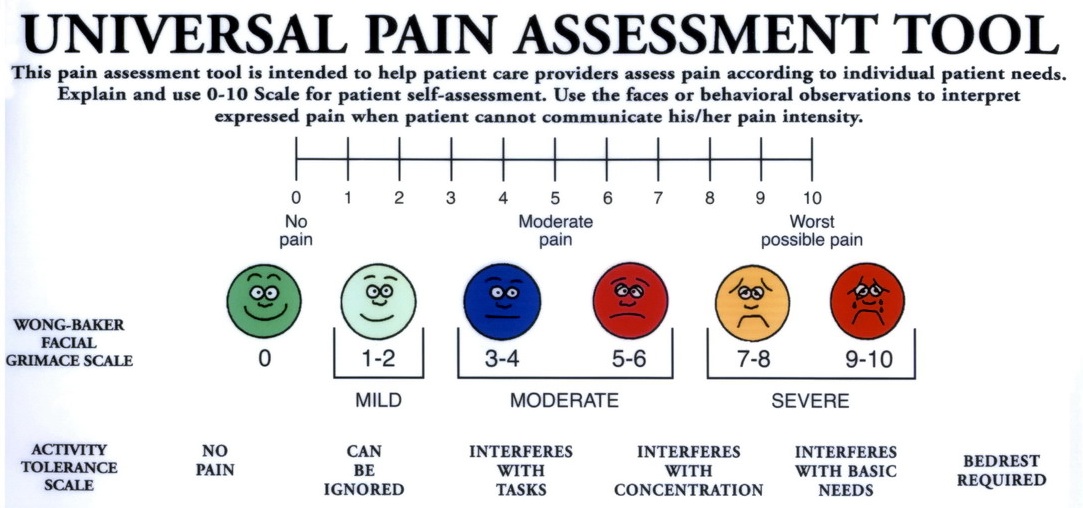
How long have you had this problem?..............................................................................................

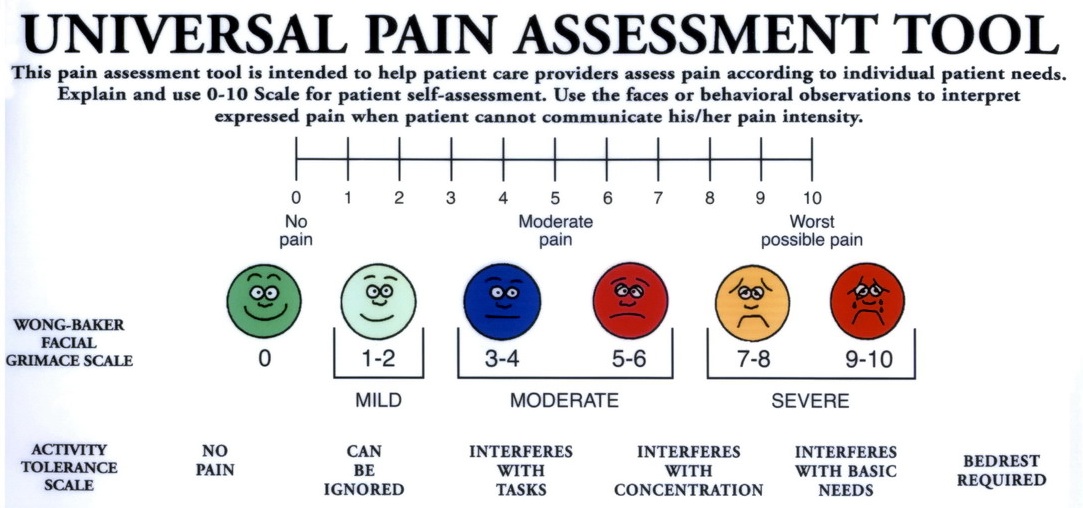
Was it similar to any problems you had in the past? Yes No When?..........................................

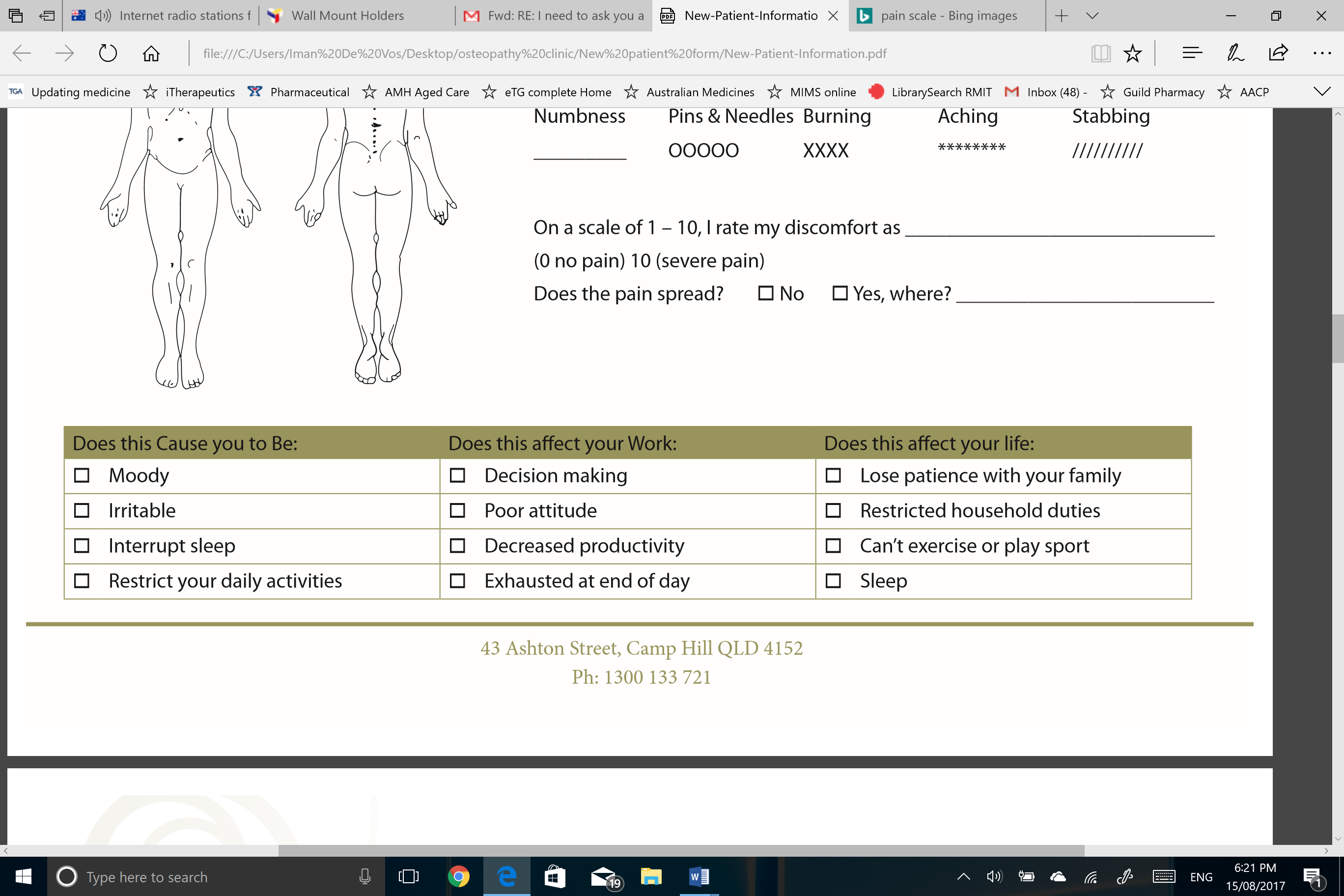
Date of last physical …………./……………/…………….

**Draw on the sketch below the area(s) you feel your problem to be**

**Please indicate the intensity of your pain on these scales ( circle each line )**







Does the pain spread/shooting?  No   Yes, Where?...............................................................

Do you have numbness?  No  Yes, where? ………………………………………………………

Do you tingling?  No  Yes, where? ………………………………………………………………..

Is there pain when you cough or sneeze?  No  Yes, where? ………………………………….

Is there pain when you sit or stand?  No  Yes, where? …………………………………….

Is the pain getting progressively worse?  No  Yes  Constant  Comes & Goes

Is the pain improving?  Getting worse  Same as before  Getting better

Do you have headaches?  No  Yes, tick all that apply:

 Tension  Throbbing  Sinus  Migraines  Other……………………………

Indicate any function below that aggravates or are aggravated by your condition (please tick all that apply):

 Walking  Steep climbing  Driving  Working  Recreation  Bowel movements  Digestion  Vision  Breathing  Sinuses  Hearing  Smelling  Sleeping  If female, menstruation  Sitting  Standing

 Other………………………………………………………………………………………………………

Indicate any function that relieves your condition:

 Painkillers  Heat  Ice  Massage  Certain positions

 Other……………………………………………………………………………………………………..

What do you hope to achieve specifically from treatment? (include goals and deadlines)

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Relevant medical details**

Allergies to anything including skin products?................................................................................

Do you take any medications including any herbal products, vitamins, minerals and supplements? (include history of long term use)

|  |  |
| --- | --- |
| Name of brand/medicine | Condition it’s used for |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Medical conditions/surgeries/ hospitalisations/injuries and accidents (include history)

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………

Have you had x-rays, CT scans or other medical imagery taken in your lifetime, please specify type and when? ……………………………………………………………………………………………..

…………………………………………………………………………………………………………………

What exercise or activities do you do?..............................................................................................

Any chance you are pregnant? Yes No Trying to conceive? Yes No