New patient registration

Title: _____

Full name: _____

Date of birth: _____

Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Best contact phone number: _____

Email address: _____

Emergency contact: _____

Phone number: _____

How did you hear about us?

- ☐ Family or friend, if so who? _____
- ☐ Internet
- ☐ Other, if so please specify: _____

Are you claiming through:

- ☐ Workcover
- ☐ TAC
- ☐ DVA
- ☐ Medicare (EPC program)

The information you provide is confidential & stored securely

Informed consent

When performed by a qualified Osteopath, our treatment techniques (including joint manipulation) are safe and effective for many painful conditions. However, like all forms of healthcare, there are some risks and it is our duty to make you aware of these. Please read the following statements and if you are content with them, please sign and date below.

- I hereby consent to the osteopathic treatment performed by Michael Viola and/or any other osteopath working at Move Osteopathic Group.
- I have the right to discuss with my osteopath the nature and purpose of my treatment.
- I understand that results are not guaranteed.
- I understand that, as in the practice of medicine, there are some slight risks to osteopathic treatment. These include and are not limited to muscle/joint soreness, muscle strains, joint sprains, fractures, disc injuries, nerve injuries, headaches, dizziness, strokes and stroke like episodes.

NB: We do have a number of diagnostic tests which may help to screen for such problems occurring.

- I understand that certain details of this form, my medical/case history as well as the nature of my treatment(s) may be communicated to other health professionals IF required.
- I understand that this consent form is valid for all consultations at Move Osteopathic Group.
- I understand that I can withdraw my consent at any time.
- I have read the above, and understand that I am free to ask questions about its content or any other issue related to my case, whether now or in the future.

Signature: _____ Date: _____

Please note that we do have a late cancellation/no show policy

Medical history

Please list any **CURRENT** illnesses, allergies, issues with your health:

-
-
-
-

Please list any **PREVIOUS** illnesses, injuries, issues with your health:

-
-
-
-

Please list any surgeries had throughout life:

-
-
-
-

Please list any medications and natural supplements you are taking:

-
-
-
-

Please list any serious medical conditions running through the family:

-
-
-
-

Lifestyle

Please list any exercises or hobbies that you regularly engage in:

-
-
-
-

How is your current diet?

☐ Good
☐ Average
☐ Poor

Does you diet consist mainly of:

☐ Processed foods
☐ Natural foods
☐ Combination of natural & processed foods

Do you follow a specific diet? If so which one:

-

Please list any known food allergies or intolerances:

-

Do you smoke?

☐ Yes
☐ No Cigarettes per day:

Do you drink?

☐ Yes
☐ No Standard drinks per day:

Systems screen

Do you have or have you recently experienced any of the following?

GENERAL

- ☐ Poor energy levels
- ☐ Difficulty sleeping
- ☐ Pain at night
- ☐ Fever/chills/sweats
- ☐ Swollen glands
- ☐ Stress
- ☐ Anxiety or depression
- ☐ Pregnancy

MUSCULOSKELETAL

- ☐ Red/hot/swollen joints
- ☐ General pain &/or stiffness

CENTRAL NERVOUS SYSTEM

- ☐ Weakness
- ☐ Numbness
- ☐ Tingling/burning/pins & needles
- ☐ Clumsiness
- ☐ Balance problems
- ☐ Twitches/tremors/seizures
- ☐ Head injuries or unconsciousness
- ☐ Changes in memory or attention
- ☐ Changes in smell or taste
- ☐ Changes in vision
- ☐ Changes in hearing
- ☐ Headaches/migraine
- ☐ Dizziness
- ☐ Vertigo

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Chest pain or discomfort
- ☐ Abnormal heart beats
- ☐ Shortness of breath
- ☐ Ankle swelling
- ☐ Skin changes
- ☐ Varicose veins
- ☐ Trouble walking short distances

RESPIRATORY

- ☐ Difficulty breathing
- ☐ Pain on breathing
- ☐ Cough
- ☐ Sputum
- ☐ Wheeze
- ☐ Persistent colds/flus/sore throat/infections
- ☐ Sinus issues
- ☐ Hay fever

GASTRO-INTESTINAL

- ☐ Pain in the abdomen
- ☐ Indigestion/heart burn/reflux
- ☐ Bloating
- ☐ Changes in bowel motions
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Nausea and/or vomiting
- ☐ Blood or mucus in your stool
- ☐ Difficulty swallowing
- ☐ Dental problems

ENDOCRINE/HORMONAL

- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Feeling too hot/too cold
- ☐ Excessive perspiration
- ☐ Increase in thirst
- ☐ Increase in urination
- ☐ Losing your hair
- ☐ Changes to your skin

URINARY

- ☐ Flank pain
- ☐ Pain on urination
- ☐ Incontinence

FEMALE REPRODUCTIVE

- ☐ Painful periods
- ☐ Irregular periods
- ☐ Unusual bleeding or discharge
- ☐ Menopause
- ☐ Infertility or difficulty falling pregnant
- ☐ Difficult pregnancy/s
- ☐ Difficult labour/s
- ☐ Cesarian birth/s

MALE REPRODUCTIVE

- ☐ Difficulty urinating
- ☐ Groin pain
- ☐ Lumps
- ☐ Erectile dysfunction