QUINTE ORTHOPAEDICS
& REHABILITATION SPECIALISTS

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or requested by law. Your written permission will be required to release any information.

Name: _____ Phone # :(H) _____(W)_____ (C)_____
Address: _____City:_____Postal Code_____
Occupation: _____ Date of birth: _____
Have you received Osteopathy before? _____ Yes _____No
Did a health care practitioner refer you for Osteopathy? _____ Yes _____No
If yes, please provide their name and address_____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ___ high blood pressure
- ___low blood pressure
- ___chronic congestive heart failure
- ___heart attack
- ___phlebitis/varicose veins
- ___stroke/CVA
- ___Pacemaker or similar device
- ___heart disease
- -Family history of any of the above ____yes ____no

Respiratory
- ___chronic cough
- ___shortness of breath
- ___bronchitis
- ___asthma
- ___-Family history of any of the above ____yes ____no

Infections
- ___hepatitis
- ___skin condition, What: _____
- ___TB
- ___HIV
- ___herpes

Other Conditions
- ___loss of sensation, Where? _____
- ___diabetes, onset:_____
- ___allergies/hypersensitivity to what: _____
- Type of reaction:_____
- ___epilepsy
- ___cancer. Where? _____
- ___arthritis
- -family history of any of the above _____yes _____no

Head and Neck
- ___history of headaches
- ___history of migraines
- ___vision problems
- ___vision loss
- ___ear problems
- ___hearing loss

Woman
- ___pregnant, due:_____
- ___gynecological conditions, What? _____

Overall, how is your general health?
_____

Family Doctor:_____
Address:_____
_____
_____

Current meds:_____
Condition it treats:_____
_____

Are you currently receiving treatment from another health care Professional? Yes_____ No _____
If yes for what? _____
Surgery-Date:_____
Nature:_____
Injury-Date:_____
Nature:_____

-Do you have any other medical conditions (eg: digestive conditions, hemophilia, osteoporosis, mental illness) ___yes ___no What? _____
-Do you have any internal pins, wires, artificial joints or special equipment? ___yes ___no
What? _____
Where? _____
What is your reason for seeking Osteopathy? Please include the location of tissue or joint discomfort?
_____

Date for new health history form:_____

Signature:_____ Date:_____

250 Sidney Street, P.O. Box 20024 • Belleville ON K8P 3Z3 • 613•962•2040
www.quinteortho.com

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MEDICAL INFORMATION RELEASE FORM

I _____, as of this date_____, do hereby authorize the release of information to_____ including all x-ray reports, hospital records, medical reports, progress notes and/or any other knowledge or information needed. I also express consent to discuss or itemize in writing any and all appropriate information.

Client Signature: _____

Dated: _____

Witness Signature: _____

Dated: _____

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