Welcome to **Osteocare**

First Name: __________________ **Surname:** ____________________**DOB:** / /
Postal Address: ____
Suburb: _______________________________________**Postcode:**__________________
Mobile Ph: ___________________________ **Home Ph:** __________________________
Email Address: ____
Occupation: __________________________ **Sports/Hobbies:** _____________________
Children (incl. names & ages) ____
____

Do you have Extras cover with a Private Health Fund? If yes:
Fund Name: ____

How did you hear about Osteocare? (Please Circle)
Internet Yellow Pages Drove Past Referral (e.g. friend, family, health professional)
Other (please specify) ___________________ If Referral, who? __________________

OBSTETRIC DETAILS

Expected date of delivery:_________________

No of weeks pregnant: _______

Trimester: **1** (1-13 weeks)
2 (13-25 weeks)
3 (26-40 weeks)

GP/Obstetrician or Midwife: _______________

Hospital: ________________________________

Emergency contact person:____

Phone No: ____

Birth Plan:____

Current scans (Type, date & results):____

Current blood tests (date & results):____

Foetal Movement:____
(Description)

1. Key reason/s for your visit to Osteocare today:
____

2. Please list any **medications and / or nutritional supplements** that you are currently taking:
____
____

3. Are you, or have you ever been, a **smoker**? Yes / No / Ex-Smoker / Social
If yes, ____**/day for** ____ **years**

4. Please list any **hospitalisations, surgeries, injuries** or **major accidents.**
(please include any fractures, car accidents, concussions, whiplash, disc injuries, child birth, etc.)

Event	Age	Event	Age
____________________	______	____________________	______
____________________	______	____________________	______
____________________	______	____________________	______

5. Have you ever, or do you currently, experience any **Cardiovascular** problems?
(e.g. angina, heart attacks, stroke, high/low blood pressure, chest pain, heart palpitations, dizziness)
Currently / Previously / No Details:
____

6. Have you ever, or do you currently, experience any **Breathing** problems?
(e.g. asthma, shortness of breath, persistent cough, wheezing, fatigue)
Currently / Previously / No Details:
____

7. Have you ever, or do you currently, experience any **Digestive** problems?
(e.g. abdominal pain, nausea, bloating, diarrhoea, constipation, vomiting, heartburn, reflux)
Currently / Previously / No Details:
____

8. Have you ever, or do you currently, experience any **Urinary / Kidney** problems? ________
(e.g. difficulty urinating, incontinence, urgency, blood in urine, lower abdominal pain, flank pain)
Currently / Previously / No Details:
____

9. Have you ever, or do you currently, experience any **Eye / Vision** problems?
(e.g. blurred / cloudy vision, eye pain / itching / redness, sensitivity to light, wearing glasses)
Currently / Previously / No Details:
____

10. Have you ever, or do you currently, experience any **Ear / Hearing** problems?
(e.g. hearing loss, ear ache / pain, ringing in the ear, discharge from ear, vertigo)
Currently / Previously / No Details:
____

11. Have undergone any **Major Dentistry** in the last 6 months?
Yes / No Details:
____

12. Have experienced any **Depression / Major Stress** in the last 6 months?
Yes / No
____

13. Do you wear **Orthotics**?
Yes / No If yes, please tell us when they were fitted:
____

14. Do you have **any other health concerns** that may be of relevance?
(e.g. current health problems not previously mentioned, diagnosed diseases, allergies, thyroid problems, recent weight loss / gain, headaches, lack of energy, difficulty sleeping, diabetes, arthritis, jaw pain, etc.)
Yes / No Details: ____

15. Please list any significant **family medical history**:
(e.g. cancer, heart disease, osteoporosis, diabetes)
____

PREGNANCY QUESTIONS

16. Have you ever, or do you currently experience any of the following?

Condition	Y / N	Condition	Y / N
Uterine Bleeding	Y / N	Placenta Insufficiency	Y / N
Abdominal Cramping	Y / N	Diabetes	Y / N
Blood Clots or Phlebitis	Y / N	Pre-Clampsia	Y / N
Lower Back Pain	Y / N	Incontinence	Y / N
Pelvic Pain	Y / N	Carpal Tunnel	Y / N
Hip Pain	Y / N	High Blood Pressure	Y / N
Pubic/Groin Pain	Y / N	Leg Cramping	Y / N
Feet Pain	Y / N	Varicose Veins	Y / N
Swelling of Feet	Y / N	Pain during sex	Y / N
Morning Sickness/Nausea	Y / N	Heart burn	Y / N
Irregular Periods	Y / N	Constipation	Y / N
Painful Periods	Y / N	Gastric Reflux	Y / N
Separation of Abdominal muscles	Y / N	Headaches	Y / N
Episiotomy / Tear	Y / N	Hemorrhoids	Y / N
Separation of Pubic Symphysis	Y / N	Other:____________ *(Please specify)*	Y / N
Bladder/Kidney Infection	Y / N		

17. Have you ever, or did you experience **difficulty falling pregnant**?
Yes / No Details:
____

Previous Pregnancies:

18. Type of birth/s: ____

19. Length of previous labour/s: ____

20. Intervention (Forceps, vacuum extraction, etc.): ______________________________

21. Problems with previous pregnancies: ______________________________

22. Miscarriages and terminations (if any): ______________________________
(Including dates and no. of weeks) ______________________________

Please read and sign the following as recognition of our clinic policies.

PRIVACY POLICY

Osteocare only collects information from our patients that is necessary in providing the best possible care and allows us to appropriately and thoroughly diagnose, treat and manage our patients. We aim to ensure that any information we hold is accurate, complete and up to date.

The health information that you provide is treated with the strictest of confidence and will only be disclosed to a third party (eg. health professional, insurance company etc.) with your written consent, unless we are legally obliged to do so.

Osteocare takes appropriate steps to ensure that all the information we hold is protected from loss, misuse, or unauthorised access, disclosure or modification. Our premise is secure, and access to our computer system is limited by user identifiers and passwords. All our staff are subject to strict obligations of confidentiality.

In handling your personal information, Osteocare is committed to complying with the Privacy Act 1988 and the National Privacy Principles (NPP) effective under the Privacy Amendment Act 2001, and operates in accordance with the Ethical Principles of the Australian Osteopathic Association.

I have read the above Privacy Statement, and consent:

Signature: ____ **Date: / /**

Patient / Parent / Guardian

CANCELLATION OR NO SHOW POLICY

Thank you for choosing Osteocare to provide your manual therapy needs. Please read the following two policies, then sign your name where indicated.

Cancellation Policy:
If you need to cancel an appointment at Osteocare, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient.

No Show Policy:
If you do not show up for a scheduled appointment you will be charged a $30 no show fee.

I understand these terms. I realise that I am financially responsible for charges.

Signature: ____ **Date: / /**

Patient / Parent / Guardian