

Medical History Form – Adults

Welcome to Osteocare. The information you provide on this form is confidential and used to determine a treatment plan.
Please complete the following to assist our Osteopaths provide you with the best possible care.

Patient Details:

Surname:	Given Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address:		Suburb:	Postcode:
Home Phone:	Work Phone:	Mobile Phone:	
Email address:		Occupation:	
Sports/Hobbies:			
Emergency Contact: Name:	Relationship:	Mobile:	
Usual GP: Name:	Phone:		
Do you have extras cover with a Private Health Insurance Fund? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: Health Fund Name: _____			

Referral details:

How did you hear about Osteocare?			
<input type="checkbox"/> Internet	<input type="checkbox"/> Referral - Please specify:	<input type="checkbox"/> Health Practitioner – Name: _____	
<input type="checkbox"/> Drove past		<input type="checkbox"/> Friend –Name: _____	
<input type="checkbox"/> Other – Please specify _____		<input type="checkbox"/> Family – Name: _____	

Key reason(s) for your visit to Osteocare:

Current medications/nutritional supplements:

Name	Reason	Name	Reason

Allergies:

Smoking status:

<input type="checkbox"/> Never smoked
<input type="checkbox"/> Ex smoker - Number per day: _____ for number of years: _____
<input type="checkbox"/> Current smoker - Number per day: _____ for number of years: _____

For women to complete:

Are you or could you be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes how many weeks? _____
How many children have you had? _____
Do any of the following apply?
<input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Unusual bleeding
<input type="checkbox"/> Pain during sex <input type="checkbox"/> Going through menopause <input type="checkbox"/> Post menopausal
<input type="checkbox"/> Difficulty getting pregnant <input type="checkbox"/> Problems during pregnancy
<input type="checkbox"/> Problems after pregnancy <input type="checkbox"/> Episiotomy/Tear

Office Use Only:	✓
Consents & Policies signed:	
Pt details updated in eAlth:	
Form scanned into eAlth:	

Medical History: (Please list any hospitalisations, surgeries, injuries or major accidents)

Event	Year/Age	Event	Year/Age	Event	Year/Age

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

Condition:	Never	Previously	Currently	Details:
Cardiovascular problems: (e.g. angina, heart attack, stroke, high/low blood pressure, chest pain, heart palpitations, dizziness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breathing problems: (e.g. asthma, shortness of breath, persistent cough, wheezing, fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Digestive problems: (e.g. abdominal pain, nausea, bloating, diarrhoea, constipation, vomiting, heartburn, reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary/Kidney problems: (e.g. difficulty urinating, incontinence, urgency, blood in urine, lower abdominal pain, flank pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye/Vision problems (e.g. blurred/cloudy vision, eye pain/itching/redness, sensitivity to light, wearing glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ear/Hearing Problems: (e.g. hearing loss, ear ache/pain, ringing in ear, discharge, vertigo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major Dentistry: (e.g. Tooth extraction, Crown, braces)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major Stress/Depression/Anxiety:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any other health concerns? (e.g. health problems not indicated above, recent weight loss/gain diagnosed diseases/ conditions, thyroid problems, , headaches, lack of energy, difficulty sleeping, diabetes, arthritis, jaw pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Thank you for choosing Osteocare to provide your manual therapy needs.

Please read the following Policies and sign below in recognition and acceptance of these Policies.

Privacy Policy:

Osteocare collects personal and medical information that is necessary to provide the best possible patient care by enabling appropriate and thorough diagnosis, treatment and management of our patients. Osteocare is committed to ensuring that any information held is complete, timely and accurate. Osteocare takes appropriate steps to ensure that all information is protected from loss, misuse, or unauthorised access, disclosure or modification. The personal and medical information that you provide is treated with the strictest confidence and will only be disclosed to a third party (eg. health professional, Solicitor/Lawyer, Insurance company) with your written consent, unless we are legally obliged to do so. The premises are secure and access to our administrative and patient records systems is restricted via user identification and password. All Osteocare Contractors and 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 within the Principles of the Australian Osteopathic Association.

Cancellation and No Show Policy:

If you need to cancel or move a scheduled appointment, Osteocare requires at least 24 hours notice so that the appointment can be offered to another patient. If less than 24 hours notice is provided, a 'Late cancellation' fee of \$30 will be incurred. Similarly, if you do not show up for a scheduled appointment and do not call to cancel a 'No Show' fee of \$30 will be incurred.

I have read and understand the above policies and realise that I am financially responsible for charges incurred from late cancellations or no shows.

Name: _____

Signature: _____
(Patient / Parent / Guardian)

Date: / /