

Patient history

Date.....

All new patients must read FORM A and complete this form before assessment and commencement of treatment. Please answer all questions and use BLOCK LETTERS.

Surname..... First name..... Date of birth.....

Address..... Suburb.....

Telephone: Home..... Work..... Mobile.....

Email.....

Current occupation..... Previous occupation.....

Main concern and known causes

.....

.....

..... Current pain level 1-10.....

About the discomfort or pain (tick all that apply to your main concern above)

Worse night morning afternoon sitting standing bending twisting

Worse with coughing, sneezing or bowel movement Worse with breathing

Burning sensation Sharp pain Shooting pain Stiffness Weakness

Bruised or sore Throbbing Numbness Dull ache Tingles

Do you have any of the following conditions?

High blood pressure Allergies Cancer Infectious conditions Pregnancy

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Which health care professionals have you previously seen?

GP Physiotherapist Chiropractor Osteopath Specialist

Name of GP.....

Did someone suggest you see Dr Hart for treatment?

Name.....

Tests you have had

X-Ray CT Scan MRI Blood tests Ultrasound Bone scan

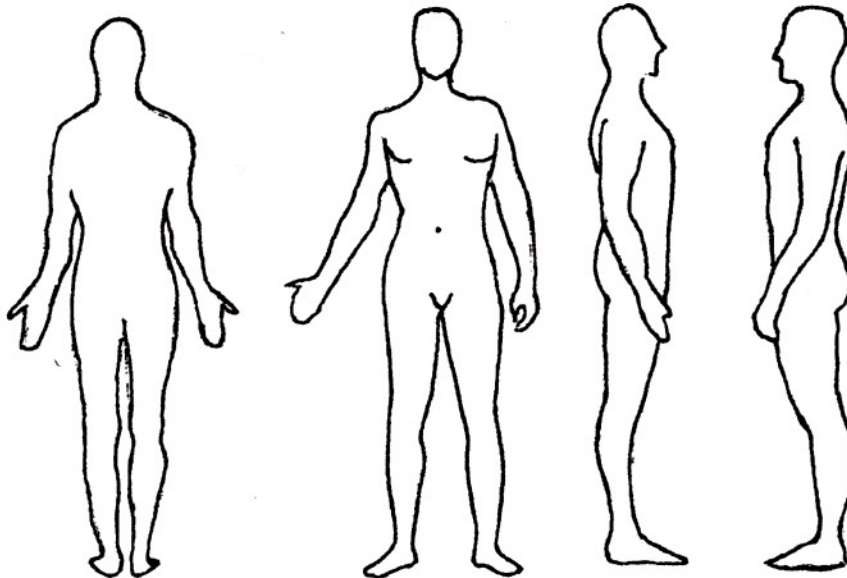
Other

Past injuries or surgery Yes No

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Current medication and condition taken for.....

Workcover claim Insurance claim Medicare EPC DVA



Please mark areas of discomfort on the above diagram.

Patient consent to Osteopathic treatment

It has been explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I acknowledge that I have discussed the risks associated with osteopathic care with Dr Christopher Hart, including specific risks associated with the treatment plan proposed for me today.

I have had the opportunity to discuss the proposed care with Dr Hart and have been given sufficient time to make an informed decision to give consent to proceed. I acknowledge that I have read FORM A, *Patient Information Regarding Consent to Osteopath Care*, provided in Dr Hart's clinic, and hereby give my consent to proceed with treatment based on the current treatment plan. I understand that I can withdraw my consent or request a different type of treatment at any time.

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Patient's signature
(parent or guardian to sign if patient is under 18 years old)

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Date