

10. Have you ever, or do you currently, experience any **Ear / Hearing** problems?

(eg. hearing loss, ear ache / pain, ringing in the ear, discharge from ear, vertigo)

Currently / Previously / No Details:

11. Have you undergone any **Major Dentistry** in the last 6 months?

Yes / No Details:

12. Have you 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?

(eg. 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)

Currently / Previously / No Details:

15. Please list any significant **family medical history** (eg. cancer, heart disease, osteoporosis, diabetes)

FOR WOMEN TO COMPLETE:

16. Are you, or could you be, pregnant?

Yes / No

If yes, how many weeks?:

17. How many children have you had? _____

18. Do any of the following apply? (Please circle)

Painful periods	Unusual bleeding	Irregular periods	Pain during sex	Difficulties getting pregnant
Episiotomy / Tear	Problems during pregnancy	Difficult post-natal period	Going through menopause	Post - Menopausal

Your privacy is of the utmost importance to us.

Please read the following outline of our privacy policy and acknowledge your understanding of how we use and protect your information.

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: / /

Informed Consent to Osteopathic Care

Osteopathic care is recognized as being an effective and safe method of care for many conditions. I hereby request and consent to the performance of osteopathic treatment (if required) and other procedures on me by the osteopath named below, and/or any other osteopath working at Osteocare.

I will have the opportunity to discuss with the osteopath the nature and purpose of the proposed course of osteopathic treatment and other procedures. I understand the results of the treatment provided to me are not guaranteed.

I understand, and am informed that, as in the practice of medicine, in the practice of osteopathy there are minor risks to osteopathic treatment, including but not limited to; muscle and joint soreness, muscle and joint sprains, fractures, disc injuries and strokes (or like episodes) and an exacerbation and/or aggravation of my presenting, or underlying, condition.

I do not expect the osteopath to be able to anticipate and explain all the risks and possible complications. I wish to rely on the osteopath to exercise judgement during the course of osteopathic treatment, which the osteopath feels at the time, based on the facts then known, is in my best interest.

I have read the above, and have also had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment at the clinic.

I understand that I can withdraw my consent to treatment at any time without prejudice.

Signature: _____
Patient / Parent / Guardian

Name: _____
Patient / Parent / Guardian

Date: / /

Osteopath: _____

Date: / /

Please Note: Persons under the age of 18 should have a parent or guardian sign this consent form.

Cancellation and 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.

If less than 24 hours notice is given I acknowledge that I will be charged a \$30 cancellation fee.

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 realize that I am financially responsible for charges incurred from cancellations or no shows.

Signature: _____
Patient / Parent / Guardian

Date: / /