MMClinic Osteopathic Intake Form

(please note your details will remain confidential & won't be released to anyone else without your authorization)

Full Name

Date of Birth

Phone Number -

Email

Occupation

Address

(STREET ADDRESS)

Marital Status

Children

Emergency Contact: Name/Relationship/Phone Number

Dr's Name & Address

How Did You Hear About Us?

Briefly describe your reason for this visit

Are you under the care of any other health practitioners?

Current Weight & Height?

Indicate any applicable:

☐ Heart/circulatory issues, eg high BP, raised cholesterol, varicose vein

☐ Respiratory, ear, nose, throat issues, eg asthma, sinus problems

☐ Dietary/digestive issues, eg constipation, diarrhea, reflux, IBS, food intolerance

☐ Bladder, kidney, urinary problems

☐ Gynaecological problems eg endometriosis, fibroids, PCOS, PMS

☐ Headaches/Migraine

☐ Nerve or muscle issues

☐ Bone or Joint problems, eg osteoporosis, rheumatoid or osteoarthritis

☐ Endocrine/hormonal issues eg thyroid, diabetes

☐ Anxiety/Depression

☐ Other

Pregnant? Y/N Weeks?

Does anyone in your immediate family suffer from:

☐ Heart problems

☐ Stroke

☐ Diabetes

☐ Cancer

☐ Epilepsy

☐ Arthritis

Please list & date any significant falls, trauma, dental work, athletic injuries or motor vehicle accidents

Please list any medications you take & the reason

Any surgery or hospitalizations ever?.....What for & when?

Do you use or do you have a history of using tobacco? Y / N

How often do you consume alcohol? Daily / Weekly /Monthly / Occasionally / Never

Please Rate Your Current Health & Fitness:

Worst 1 2 3 4 5 Best

How Many Times A Week Do You Exercise & What Sort Of Activity?

DATE