Essendon Osteopathic Health Care

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PATIENT DETAILS

Title: Mr / Mrs / Ms / Miss (please circle)

Surname:_____ **First Name:**_____

Date of birth:_____ **Sex: Male / Female (please circle)**

Address:_____**Suburb:**_____ **Post code:**_____

Telephone (home):_____**Telephone (work):**_____

Telephone (mobile):_____

Email Address:_____

Marital Status:_____ **Country of Birth:**_____

Occupation:_____ **Full-time / Part-time / Casual (please circle)**

Does the occupation involve lifting...Y/N, repetitive movement... Y/N, sitting... Y/N, standing... Y/N

Doctor's details:

Name:_____

Address:_____

_____

Medical Claims: Workcover / TAC / Private Health / Other (please circle)

Please state your private health insurance company_____

Only complete if you are claiming Workcover or TAC

Claim number:_____ **Date of Injury:**_____

Insurance Company:_____

Employer:_____

Workplace Address:_____ **Post code:**_____

PRIVACY POLICY

Information about your medical and family health history is required for us to enable accurate diagnosis and treatment. This information is collected from you with your consent. We also may collect information from others such as x-rays, and for this prior permission will be sought.

Medicare, DVA and workers compensation schemes require a range of information to be kept by all health practitioners. Some information about you is also provided to Medicare and private health funds if relevant, for billing and medical rebate purposes. To ensure quality and continuity of care, your health information may have to be shared from time to time.

There are also circumstances where health practitioners are legally bound to disclose personal information. We are also required to keep your information from your last attendance for as long as 7 years.

Access to your information

You have the right to access your information or ask for a copy of a part of the whole record. The request should be in writing, and a charge will be payable where the practice incurs a cost in providing access, particularly if you want a copy. This is allowed under privacy guidelines.

If our material is subject to copyright you may be prevented to further copying without the osteopaths permission.

Upon request we may disclose your information to other health service providers.

Parents/Guardian Children

Under privacy guidelines, the rights of children to privacy of the health information based on the professional judgement of the osteopath and consistent law, might at times restrict access to this information by parents or guardians.

If you have concerns discuss this information with your osteopath, or the practice manager. If you are still dissatisfied you can complain to the **Federal Privacy Commissioner.**

COMPLAINS OF.

- ❑ Site (Where exactly)
- ❑ Type of pain/abnormal feeling
- ❑ Deep, superficial &/or difficult to define
- ❑ Radiation or pain elsewhere
- ❑ Severity (0-10) 0 10
- ❑ Associated numbness Tingling or weakness
- ❑ Associated headaches / N & V
- ❑ Any other problems

HISTORY OF PRESENTING COMPLAINT.

First onset – when exactly did this occur
Nature of Onset
Have you ever had this before.
Cause (What doing).
Pain Sudden or gradual onset
Severity at the time.
Increasing in severity
Pattern during day/Week
Constant or variable
Have symptoms changed since pain began.
Does the pain wake you at night.

PREVIOUS TREATMENT OR INVESTIGATIONS.

- ❑ Did you receive any other treatment. When. For How Long.
- ❑ Who.
- ❑
- ❑ Diagnosis
- ❑ Drugs Prescribed.
- ❑ Tests done.
- ❑ X-rays taken.

Agg

.

Rel.

Is relief partial or complete, and for how long.

PAST MEDICAL HISTORY.

- Surgery.
- Accidents (MVA's)/ Injuries.
- Other hospitalisations
- Specific disorders.

CVD- Heart- Strokes.
Diabetes / Asthma
TB / HIV.
Jaundice / Hepatitis.
Cancer / Anaemia

DRUG HISTORY & ALLERGIES (ILLNESS SURGERY TRAUMA, PAST LONG TERM DECICATION)

FAMILY HISTORY (FAMILY HISTORY OF DISEASE OR CONDITIONS)

SOCIAL HISTORY

SYSTEMATIC ENQUIRY

CVS & RESP.

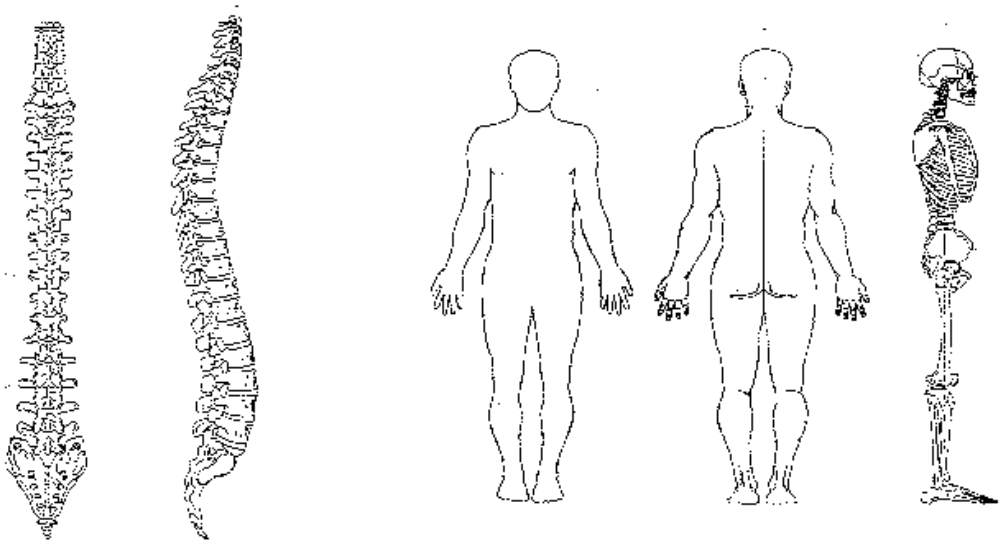
G.I.

G.U.

MUSC/SKEL

CNS

ENDO



Active ROM *(Contin)*

Palpatory findings

Segmental assessment
Passive ROM

Tests

Diagnosis

Investigations

Patient consent to treatment and management

Osteopathic care is recognised as safe and effective in the treatment of many conditions. Whilst it is safe there are always potential risks associated with treatment procedures and as such you need to be informed.

Please read the following carefully and ask any questions that need to be clarified.

1. I have disclosed all information regarding my past and present health
2. I have had the opportunity to discuss my proposed care and ask questions regarding the nature extent and purpose of my proposed care and i have been given sufficient time to make a decision giving consent for treatment to proceed.
3. I acknowledge that I have discussed the risks associated with my proposed care, such as muscle and joint soreness, headaches, disc injuries, pinched nerves, soft tissue strains, nausea and dizziness fractures exacerbation and/or aggravation of underlying conditions.
4. I acknowledge that I have discussed the rare risks associated neck manipulation such as mentioned above, and also with artery damage that may cause stroke or stroke like episodes. I have discussed alternatives to manipulation.
5. I acknowledge that I am aware of and understand the potential risks. I appreciate the results are not guaranteed. I do not expect that the osteopath will be able to anticipate all possible risks and complications associated with my proposed care.
6. I hereby acknowledge my consent to the performance of the proposed osteopathic care as outlined above inclusive of neck manipulation if prescribed, and understand that I can withdraw my consent at any time.

*Patients's signature:*_____ *Date:*_____

Patient's name:_____

Doctor's signature: *Date:*

Initial Treatment

Prognosis

Advice/Action Notes

PROGRESS NOTES

Date	Prob No.	SOA	FINDINGS: Subjective Objective Assessment	DTI	PLANS: Diagnostic. Therapeutic (including medication), Information