WILDFLOWER HEALTH AND WELLNESS (http://www.wildflowerhw.com)

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# Profile Information — Step 1 of 3

*You are completing the following intake forms: Osteopathic Manual Practitioner Intake form (October 2019)*

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

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*** (required) First Name**

First Name

*** (required) Last Name**

Last Name

**Preferred Name**

**Prefix / Title**

▼

*** (required) Email**

Email Address

**Mobile Phone**

▼

*Please provide at least one phone number. Your mobile number can be used to look up your account and receive text message appointment reminders.*

**Home Phone**

▼

**Country**

Canada ▼

**Street Address**

Suite Number (i.e. Suite #100)

**City**

**Province**

▼

Postal / Zip

Date of Birth

Gender

*Refers to current gender which may be different than what is indicated on your insurance policies.*

Sex

*This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file.*

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of referring professional

Referring professional phone (if known)

Referring professional email (if known)

How did you hear about us?

How did you hear about us?

Who were you referred to?

Wildflower Health & Wellness ▼

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# Questionnaires — Step 2 of 3

*You are completing the following intake forms: Osteopathic Manual Practitioner Intake form (October 2019)*

## Osteopathic Manual Practitioner Intake form (October 2019)

*Please tell me about your chief concern(s) for which you are seeking treatment. Circle the area of the body on the chart below and describe what is happening in each area in the space provided below the body chart.*

**Primary Concern(s)**

**Additional Concern(s)**

**Have you had any traumas, accidents, or injuries that could have contributed to these concerns?**

**Have you had any imaging done of these or other areas (ex. X-ray, MRI, CT, etc.)?**

**What surgeries have you had? Description and Date**

**Special note about surgery: pins, wires, mesh, prosthetic, walker, cane. etc.**

**On a scale of 1 to 10, how would you rate your stress level? What are some of your stressors?**

**Describe your exercise or activity level.**

**Please tell me about your sleeping patterns.**

- [ ] Number of hours per night
- [ ] Restful
- [ ] Restless
- [ ] Number of times you wake per night
- [ ] Reason for waking

**Are you currently receiving any of the following therapies? If so, please indicate the frequency of these treatments.**

- [ ] Massage Therapy
- [ ] Chiropractic
- [ ] Physiotherapy
- [ ] Naturopathic Medicine
- [ ] Medical Doctor
- [ ] Other

*Have you ever experienced/had trouble with any of the following? Please check all that apply.*

**Musculoskeletal System**

- Acute muscle and joint pain
- Chronic muscle and joint pain
- Swollen/stiff joints
- Numbness in arms or legs
- Back pain
- Jaw pain
- Rheumatoid arthritis
- Osteoarthritis
- Spondylolisthesis
- Tendonisis/Bursitis
- Scoliosis
- Artificial joints, pins, or wires

**Cardiovascular/Respiratory System**

- Chest pains
- Heart palpitations
- Pacemaker
- Heart disease
- Heart attack
- High blood pressure
- Low blood pressure
- Stroke
- Chronic cough/cold/flu
- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Anaemia
- Deep vein thrombosis
- Varicose veins

**Digestive System**

- Painful bowel movements
- Haemorrhoids
- Chronic bloating
- Acid reflux
- Hiatal hernia
- Ulcer(s)
- Nausea
- Increased food sensitivities
- Loss/increase in appetite
- IBS
- Colitis
- Constipation
- Diarrhea
- Crohn's disease
- Diabetes
- Gall stones
- Hepatitis
- Cirrhosis
- Liver/Gall bladder dysfunctions

**Nervous System**

- Paralysis
- Numbness/tingling sensation
- Balance loss
- Epilepsy
- Fainting
- Degenerative disease

**Head/ENT**

- [ ] Headaches/Migraines
- [ ] Dizziness/Vertigo
- [ ] Loss of vision
- [ ] Earaches
- [ ] Tinnitus/hearing loss or dysfunction
- [ ] Congested sinuses
- [ ] Loss of smell/taste
- [ ] Memory loss
- [ ] Fatigue/Sleep disorder
- [ ] Chronic laryngitis/pharyngitis/tonsilitis
- [ ] Dental surgery

**Reproductive/Urinary System**

- [ ] Kidney stones
- [ ] Kidney failure
- [ ] Painful urination
- [ ] Incontinence
- [ ] Urgency
- [ ] Bladder prolapse
- [ ] Chronic urinary tract infections
- [ ] Chronic yeast infections
- [ ] Prostate dysfunction
- [ ] Sexual dysfunction

**Endocrine System**

- [ ] Hormone imbalance
- [ ] Thyroid dysfunction
- [ ] Pancreatic dysfunction
- [ ] Pituitary gland dysfunction
- [ ] Pineal gland dysfunction
- [ ] Gonadal dysfunction

**Immune and Lymphatic System**

- [ ] Edema
- [ ] Lymphedema
- [ ] Autoimmune disorder

**Integumentary System**

- [ ] Sensitive skin/rashes
- [ ] Eczema/psoriasis
- [ ] Acne
- [ ] Herpes
- [ ] Parasitic infections
- [ ] Dermatitis

**Mental Health**

- [ ] Anxiety
- [ ] Depression
- [ ] Bipolar disorder
- [ ] OCD
- [ ] Substance abuse
- [ ] ADD/ADHD

**Women's Health**

- [ ] Pain, heaviness, or irregular menstruation

- [ ] Endometriosis

- [ ] Birth control

- [ ] Pregnancy(s)

☐ Abortion(s)

☐ D & C

☐ Prolapse

☐ Menopausal

☐ Cystic or tender breast tissue

☐ Breast feeding

**Is there any relevant family (genetic) medical history that you think I should know?**

**Any previous/current medical diagnosis**

**Are you currently on any prescription medication, vitamins, or supplements?**

**What are your expectations or goals for receiving treatment?**

**CONSENT to Treatment & Collection/Use of Information-PHIPA & Your privacy**

CONSENT to Treatment & Collection/Use of Information-PHIPA & Your privacy

The Personal Health Information Protection Act (PHIPA), is Ontario legis lated established in November 2004 and amended in 2016. PHIPA provides a set of rules for the collection, use and disclosure of personal health information. In accordance with PHIPA, AMIT

**CONSENT to Treatment & Collection/Use of Information-PHIPA & Your privacy**

- [ ] By agreeing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above. I have reviewed the above information that explains how Amit Dureja, M.OMSc.,irrespective of the clinics in which he practices, will use my personal information, and the steps that he is taking to protect my information.
  - [ ] I agree that Amit Dureja, M.OMSc. may collect, use and disclose personal information as set out above in the information about Amit Dureja, M.OMSc. and his privacy policies.

**Consent for Treatment**

- [ ] I understand that the Manual Osteopathy is providing manual therapy services within their scope of practice. I hereby consent to my Manual Osteopathy to treat me with manual therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Manual Practitioner. I acknowledge that the Osteopathic Manual Practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that manual osteopathy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I acknowledge and understand that the Osteopathic Manual Practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Practitioner and have disclosed to the Osteopathic Manual Practitioner, all those medical conditions affecting me. It is my responsibility to keep the Osteopathic Manual Practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my Osteopathic Manual Practitioner from time to time, to deal with my physical conditions and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Continue

# Consents — Step 3 of 3

*You are completing the following intake forms: Osteopathic Manual Practitioner Intake form (October 2019)*

## Email Communication

### Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [x] I would like email notifications of new, cancelled, and rescheduled appointments
- [ ] Email 2 days before appointment

### News and Special Promotions

- [ ] Yes, I would like to receive news and special promotions by email

## Osteopathic Manual Practitioner Intake form (October 2019) — Consents

### Accuracy of Information

- [ ] * (required) I certify that the above medical information is correct to my knowledge.

### Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] * (required) I agree

## Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 48 hours notice for any cancellations or changes to your appointment. Patients who provide less than 48 hours notice, or miss their appointment, will be charged a cancellation fee.

- [ ] * (required) I am aware of the Cancellation Policy.

## Agency

I also confirm that I have the ability to accept or reject this care of my own free will and I am not an agent of any private, local, provincial, or federal agency attempting to gather information without stating. I accept full responsibility for any fees incurred during care and treatment.

- [ ] * (required) I confirm

## Email consent

I authorize the clinic and its associated health professionals to communicate with me regarding appointments and/or any other clarification regarding instructions given during appointments by my practitioner.

○ **I consent to email communication**

○ **I do not consent to email communication**

Submit Intake Form