Patient Name: _____

Heather Pierce RMT DOMP

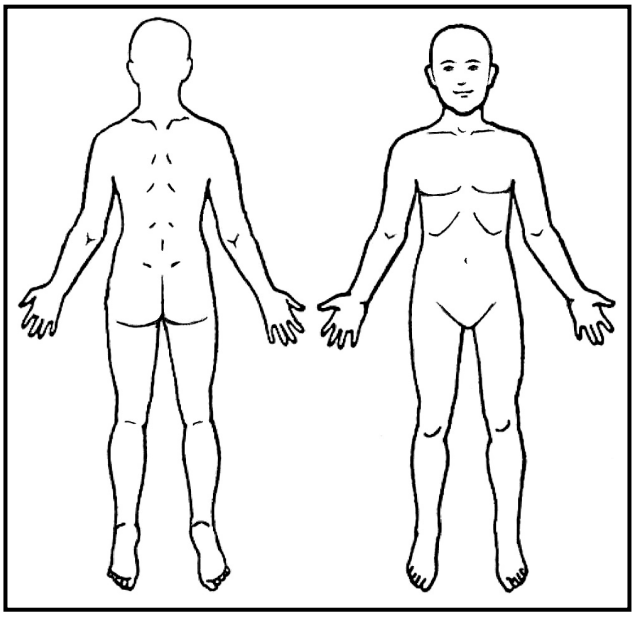
Personal History

Last name: _____ First name: _____Initial:_____
Mailing Address: _____
City: _____Province: _____Postal Code: _____
Home Phone: _____ Cell: _____
email: _____ _____
Birth date: Day _____Month _____ Year ____ Gender Identity: _____
Sex assigned at birth: _____ Occupation: _____ Age: _____
Health Card Number: _____Medical Doctor: _____
Hobbies/Activities: _____
Who may we thank for referring you to this office? _____

Current Health Condition

Current Complaint(s):_____
When did the condition begin? _____ Has the condition occurred before? Yes ☐ No ☐
How did the condition begin? _____
Is the condition: ☐ Job-related ☐ Auto-related ☐ Fall or Trauma ☐ Repetitive stress
Date of Accident: _____ Time of Accident: _____
Have you seen anyone else for this condition? _____
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent ☐ Other: _____

Place a mark (/) on the line below to indicate the severity of your symptoms:
NO SYMPTOMS _____ *WORST POSSIBLE SYMPTOMS*



Please use the symbols provided below to outline on the diagram the area of your discomfort and any radiation of pain.

X	Sharp Pain
///	Dull Pain
:::	Numbness
==	Stiffness
~~	Burning Pain
	Other

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What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Sleeping ☐ Desk work
☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Condition is getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Please describe how it feels when this problem is at its worst: _____

Past Health History

Major Surgery/Operations: ☐ Back Surgery ☐ Heart Surgery ☐ Hip or Knee ☐ Other: _____

Major illness (past /present) ☐ Cancer ☐ Other: _____

Broken bones: ☐ Spinal fracture ☐ Leg or ankle ☐ Collar bone ☐ Other: _____

Sprained/torn ligaments ☐ Knee ☐ Ankle ☐ Shoulder ☐ Other: _____

Past Trauma: ☐ Childhood Traumas _____ ☐ Sports Injuries _____
☐ Motor Vehicle Accidents _____ ☐ Work Injuries _____

Do your wear orthotics or corrective footwear? ☐ Yes ☐ No

Have you had X-rays or an MRI/CT taken? ☐ Yes ☐ No If yes, when? _____

Health History:

Muscle/Joint Pain

☐ Neck
☐ Jaw
☐ Back (upper)
☐ Back (mid)
☐ Back (lower)
☐ Shoulders
☐ Elbow
☐ Wrist/hand
☐ Hip
☐ Knee Pain
☐ Foot / Ankle Pain
☐ Joint Pain / Stiffness
☐ Spine
☐ General Stiffness

Head and Neck

☐ history of headaches
☐ History of migraines
☐ Vision problems
☐ Vision loss
☐ Ear problems
☐ Hearing loss
☐ Major dental work

C-V-R

☐ High blood pressure
☐ Low blood pressure
☐ Chronic congestive heart failure
☐ Heart Attack
☐ Phlebitis/ Varicose Veins
☐ Stroke/CVA
☐ Pacemaker or similar devise
☐ Heart Disease

Infections

☐ Skin conditions
☐ Hepatitis
☐ other:

Digestive

☐ Constipation
☐ Crohn's Disease
☐ Colitis
☐ Irritable bowel syndrome
☐ Ulcers
☐ other:

Respiratory

☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic cough
☐ Shortness of breath

Skin Conditions

☐ Eczema
☐ Psoriasis
☐ Rash
☐ Warts
☐ Open sores

Female

☐ Menstrual problems
☐ Menopausal problems
☐ Vaginal Pain / Infections
☐ Breast Pain / Lumps
☐ Pregnancy date:
☐ number of pregnancies:
☐ Hysterectomy

Patient Name: _____

Heather Pierce RMT DOMP

Workplace Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Do you have a regular exercise program?

- ☐ Yes
- ☐ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Other

- ☐ Loss of sensation

Where?

- ☐ Diabetes/ Onset::

Type

- ☐ Allergies/hypersensitivity

What?

- ☐ Epilepsy
- ☐ Cancer

Type/location:

- ☐ Arthritis
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Hypothyroidism/hyper
- ☐ Sleep

Check the medication(s) that you take regularly

- ☐ Insulin
- ☐ Antacids
- ☐ Heartburn medication
- ☐ Laxatives
- ☐ Arthritis medication
- ☐ Muscles relaxants
- ☐ Blood pressure medication
- ☐ Birth control pills
- ☐ Pain killers
- ☐ vitamins
- ☐ Other: _____

_____

_____

Birth or Early Childhood Story/History (if relevant)

CONSENT, WAIVER AND RELEASE FOR OSTEOPATHIC TREATMENT

Heather Pierce RMT, DOMP

I, _____, hereby acknowledge that:

□ I am attending for Osteopathic treatment today **or** □ **I am the parent/guardian of a minor child attending for Osteopathic treatment today.** (*Select one*)

I have had the nature and purpose of the proposed Osteopathic treatments and techniques explained to me by the treating Osteopath, Heather Pierce. I understand that Osteopathy is not a substitute for treatment by a licenced medical practitioner, and that it is recommended that I work concurrently with my physician to address any health conditions. I confirm that I have fully disclosed my (or my child's) medical history, family history, and medication and/or supplement history, and any other pertinent health information, and agree that it is my responsibility to continue to update Heather Pierce RMT, DOMP about any developments or new information.

I have been informed that Manual Osteopathy involves using manual techniques with the goal of achieving optimal function of the body's systems. Heather Pierce and I have discussed the risks and any potential side effects, as well as the anticipated benefits of the proposed Osteopathic treatments and techniques. I have had the opportunity to ask any questions and am satisfied with the answers that I received. I understand that results are not guaranteed. I am aware that certain techniques may result in complications such as headache, fatigue, muscle ache, neuromuscular dysregulation, lymphatic dysregulation, cardiovascular dysregulation, or any flare up in current symptomatology during or after treatment, and may

Patient Name: _____

result in injury (or death). If I experience pain or discomfort during treatment, I acknowledge that it is my responsibility to inform my Osteopath immediately. I acknowledge that I (or my child) may ask to stop treatment at any point during my session and that a request to stop treatment will withdraw my consent to any further treatment from that point forward only.

I voluntarily consent to take part in Osteopathic treatment today (or for my child to take part in Osteopathic treatment today) and to assume the risks associated with treatment. **I agree not to hold** Heather Pierce **and** Heather Pierce RMT, DOMP **liable for any injury suffered as a result of any Osteopathic treatment provided to me or my child, and hereby waive, release and forever discharge** Heather Pierce **and** Heather Pierce RMT, DOMP **from any claims, damage, actions, costs, or expense associated with the treatment I or my child have received.**

_____ _____ _____

Signature of Patient/Decision Maker | Date | Name of Minor Child (*if applicable*)

COVID-19 CONSENT AND WAIVER: I am aware that Osteopathy involves techniques that will place me (or my child, if consenting on behalf of a minor child) in close physical contact with the Osteopath, making physical distancing impossible and leading to an increased risk of transmission of COVID-19. I have reviewed the safety information provided by Heather Pierce RMT, DOMP and agree to follow required procedures set out therein. I agree not to hold Heather Pierce and Heather Pierce RMT, DOMP liable should I/my child contract COVID-19 as a result of attending or receiving treatment at Heather Pierce RMT, DOMP.

I agree and acknowledge that I/my child am not presenting with any symptoms of COVID-19 today, and will inform Heather Pierce RMT, DOMP immediately if I/my child test positive for COVID-19 within the next 14 days. I acknowledge that if I/my child do not comply with Heather Pierce RMT, DOMP's safety procedures, Heather Pierce may stop treatment and I/my child may be asked to leave immediately. I agree to indemnify and save harmless Heather Pierce and Heather Pierce RMT, DOMP for any intentional refusal by me/my child to follow safety protocols that were provided to me.

_____

Signature of Patient/Decision Maker

Missed Appointment and Cancellation Policy

We require 24 hours notice for cancellation of appointments as we have set aside that appointment time for you. We will bill you directly the full cost of the treatment for missed appointments without adequate notice. If you need to cancel your appointment due to possible COVID-19 or COVID-19, you will not be charged.

I intend this consent to apply to all my present and future Massage Therapy and Osteopathic care.

Dated this _____ day of _____, 20___.

_____

Patient Signature (Legal Guardian)

Name: _____

(please print)