Medical History Intake & Consent Form	Genevieve Stewart, RMT, DO(MP)

Name (Please Print): _____

- I give permission for my health history to be collected for the sole purpose of formulating a treatment plan.
- I give permission for Genevieve Stewart, RMT, DO(MP), to contact me via mail (i.e. newsletters, cards, etc.).
- I hereby authorize Genevieve Stewart, RMT, DO(MP), to have access to this file for professional purposes. All information that I provide will be kept confidential except as required by law. I understand that I will be asked for written authorization before this information can be released outside this clinic.
- I certify that the information given in this form is correct and accurately reflects my past and current health status. I will notify the therapist of any changes that occur as soon as possible.
- I hereby give consent for treatment; my consent can be revoked at any time I choose. I understand that I am being treated by an Osteopathic Manual Practitioner and will be billed as such.
- I understand that therapists, and osteopathic manual practitioners do not diagnose illness, disease and/or physical or mental disorder. I acknowledge that treatment is *not* a replacement for medical advice and should see my medical doctor for that service.
- I agree to provide **24 hours notice to change or cancel my appointment** or I will be charged the full appointment fee.

Signature: _____ Date: _____

General Information

How did you hear about us? _____

Home Address: _____ **City:** _____ **Postal Code:** _____

Home Phone: (____)_____ **Work: (____)**_____ **Cell: (____)**_____

Date of Birth (Month/Day/Year): ____/_____/_____ **Occupation:** _____

Physician's Name: _____ **Date of Last Physical:** _____ **Results:** _____

Main Reason for Coming: _____

Other Health Care in Past Year? (Please circle all that apply): Acupuncture Homeopathy Massage Osteopathy Reflexology Shiatsu Other (please specify): _____

Current Medications (and conditions they are treating): _____

_____

Regular Exercise: _____

Please Check Any Conditions If Experienced **DURING** Exercise:

- ☐ Extreme Muscle Soreness
- ☐ Headaches
- ☐ Extreme Muscle Weakness
- ☐ Difficulty Breathing
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Other: _____

Recent Hospitalizations (Date/Why): _____

Surgeries (Date/Current Symptoms): _____

_____

Injuries (Date/Current Symptoms): _____

Please check any condition below that you are currently experiencing or have had in the past in the corresponding boxes:

Arthritis Conditions:	Current	Past	**Genitourinary Conditions:**	Current	Past	**Systemic Conditions**	Current	Past	**Musculo-Skeletal:**	Current	Past
Ankylosing Spondylitis			Constipation			Diabetes			Osteoporosis		
Degenerative Discs			Gas/ Bloating			Fatigue			Joint or Bone Disease		
Gout			Nausea			Lupus			Tendonitis/ Bursitis		
Osteoarthritis			Irritable Bowl Syndrome			Fever/ Chills /Night sweats			Spasms/ Cramps		
Rheumatoid Arthritis (Where: _____)			Urination Problems: _____			Fainting / Dizziness			Fibromyalgia		
			Liver/ Gall Bladder: _____			HIV/AIDS			Head Aches/ Migraines		
			Kidney/ Bladder: _____			Infectious Disease			Jaw Pain/ TMJ		
Blood Conditions:			Hernia			Other: _____			Neck/ Upper Back Pain		
Anemia			Poor Appetite						Mid/ Low Back Pain		
Hemophilia			Other: _____			**Women Only:**			Shoulder/ Arm Pain R/L		
Leukemia						Pregnant (Due: _____)			Elbow/ Forearm Pain R/L		
						Menstrual Problems			Wrist/ Hand Pain R/L		
Respiratory Conditions:			**Circulatory Conditions:**			Menopausal Problems			Hip/ Gluteus Pain R/L		
Asthma			Heart Attack			Endometriosis			Leg/ Knee Pain R/L		
Pneumonia			Angina			Fibroids			Ankle/ Foot Pain R/L		
Chronic Bronchitis			Heart Palpitations			Other: _____			Other: _____		
Emphysema			Stroke								
Sinusitis			Blood pressure (High/Low)			**Skin Conditions:**			**Other Conditions:**		
Sinus Congestion			Arteriosclerosis			Allergies			Cancer/ Tumours		
Shortness of Breath			Arteritis-inflamed artery			Hypersensitivity/ Hives			Alcohol/ Drug Addiction		
Chronic Cough			Phlebitis-inflamed vein			Bruises Easily			Vision Problems		
Tuberculosis			Varicose veins			Rashes/ Itching			Hearing Problems		
Other: _____			Aneurysm			Skin Conditions			Anxiety/ Nervousness		
			Thrombosis			Poor Healing			Dental Problems		
Nervous System:			Blood Clots			Eczema			Loss of Sleep/ Insomnia		
Epilepsy/ Convulsions			Raynaud's Disease			Athletes Foot			Other: _____		
Paralysis			Buerger's Disease			Warts					
Multiple Sclerosis						Other: ____					
Numbness/ Tingling											
Other: _____											

Do you have any internal pins, wires, or artificial joints, a pacemaker, or special equipment? No Yes

If yes please provide details: _____