Manual
Therapy

2310 College Avenue
Regina, SK

Date:___________________________

Name First	Last		
Address Street			
City	Prov	Postal Code	
Telephone Home	Work	Cell	
DOB (dd/mm/yy) ☐F ☐M		**Email**	
Occupation	**Children** (Ages)		
Duties	**Height/Weight**		

Referred by
Family Physician (name)
Address

Past	Present	Therapy	Therapist
		Massage Therapist	
		Chiropractor	
		Physiotherapist	
		Dentist/Orthodontist	
		Other	
		Other	

What is the main reason for your visit today?

Please check any conditions you had in the past or are suffering currently		
☐ Cancer	☐ Seizures	☐ Celiac disease
☐ Diabetes	☐ Multiple Sclerosis	☐ Mental illness
☐ Heart Disease	☐ Asthma	☐ Arthritis
☐ Stroke	☐ Allergies	☐ Autoimmune disease
☐ High blood pressure	☐ Anemia	☐Osteoporosis
☐ Measles	☐ Mumps	☐ Rubella
☐ Chicken pox	☐ Rheumatic Fever	☐ Polio
Other (please specify)		

Surgeries/hospitalizations	
Year	**Type/Reason**

Past History ○ Description of accidents (car, motorcycle, sports, ski, bike, etc.), falls, concussions, blows to the head or body ○ Stressful events or important life changes (divorce, death, moving, changing jobs, abuse, assault) ○ Birth details (were you the first baby, premature, full term, late, induced, vacuum/ forceps, etc…)	
Year	**Incident/Reason**

Please list any prescribed medication, over-the-counter drugs, vitamins or herbs you are taking

Medical Tests Please list any X-rays, ECG, CT Scan, MRI, Ultrasounds…that you have had in the past		
Date	Test	Result

Please list any allergies you have

Health Habits		
Exercise/Hobbies (type, frequency)		
Diet	☐Vegetarian ☐Vegan	Are you on a particular diet at present? (Type)
Water	How many glasses of water do you drink in a day?	
Caffeine	☐Coffee ☐Tea ☐ Cola	Cups/Cans per week?
Alcohol	Do you drink alcohol	Drinks per week? Type

	☐Yes ☐No	
Tobacco	Do you smoke or use smokeless tobacco? ☐Yes ☐no	Quantity per day?
Do you have difficulty sleeping? ☐Yes ☐No	**Hours of sleep per night**	

Family Medical History Please check off any conditions a family member has suffered. Please indicate whose side it was on (M- Mother, F- Father)		
☐Cancer ☐M ☐F	☐Seizures ☐M ☐F	☐Celiac Disease ☐M ☐F
☐Diabetes ☐M ☐F	☐Multiple Sclerosis ☐M☐F	☐Mental Illness ☐M ☐F
☐Heart disease ☐M ☐F	☐Asthma ☐M ☐F	☐Arthritis ☐M ☐F
☐ Stroke ☐M ☐F	☐ Allergies ☐M ☐F	☐Autoimmune disease ☐M ☐F
☐High Blood Pressure ☐M ☐F	☐Anemia ☐M ☐F	☐Osteoporosis ☐M ☐F
Other Please Specify		

Please check off any conditions you are suffering from or have suffered in the past.

General		
☐Poor Appetite	☐Strong thirst	☐Weight gain
☐Change in appetite	☐Night sweats	☐Weight loss
☐Poor sleep	☐Recurring infections	☐Chills
☐Fatigue	☐Bleed/ bruise easily	☐Fevers
☐Cravings	☐Peculiar tastes or smells	☐Blackouts
☐Restless Legs Syndrome	☐Other	

Skin		
☐Rashes	☐Dry hair/skin	☐Recent moles/changes
☐Itching	☐Hair loss	☐Ulcerations
☐Eczema	☐Dandruff	☐Other hair/skin problems

Ears , Eyes, Nose and Throat		
☐Eye pain	☐Cataracts	☐Nose bleeds
☐Eye strain	☐Ear ache	☐Recurrent sore throats
☐Wear glasses	☐Poor Hearing	☐Sores on lips/ tongue
☐Blurry vision	☐Ringing in ear	☐Polyps in nose
☐Night blindness	☐Facial pain	☐History of nose injury or fracture
☐Color blindness	☐Sinus problems	☐Other

Dental		
☐Face pain	☐Have you worn braces?	☐Wisdom teeth removed
☐Teeth removed	☐Jaw painful or clicks	☐Other major dental work
☐Toothache	☐Do you wear dentures or a bridge?	☐Trauma to teeth
☐Mercury (silver) fillings	☐Root canals	

Heart and Circulation		
☐High blood pressure	☐Varicose veins	☐Shortness of breath
☐Low blood pressure	☐Blood clots	☐High cholesterol
☐Irregular heart beat	☐Deep vein thrombosis	☐Leg pain with walking that is eased by stopping or rest
☐Dizziness	☐Cold hands/feet	☐Other
☐Fainting	☐Swelling of hands	☐
☐Chest pain	☐Swelling of feet	☐

Digestion and Elimination		
☐Indigestion/burning/reflux	☐Abdominal cramps	☐Pain passing bowel motion
☐Gas	☐Nausea	☐Blood in stools
☐Bad breath	☐Vomiting	☐Fatty stools
☐Constipation	☐Chronic laxative use	☐Gallstones
☐Diarrhea	☐Rectal pain	☐Gallbladder/liver problems
☐Bloating	☐Hemorrhoids	☐Other

Lungs and Breathing		
☐Breathlessness	☐Coughing blood	☐Pain with a deep breath
☐Wheezing	☐Bronchitis	☐Collapsed lung
☐Cough	☐Pneumonia	☐Other
☐Phlegm (color)	☐Asthma	☐

Genito - Urinary		
☐Frequent urination	☐Unable to hold urine	☐Bladder/ kidney infections
☐Urgency to urinate	☐Strong smelling urine	☐Impotency
☐Pain on urination	☐Distinctive odor or color	☐Other
☐Do you wake at night to urinate?	☐Blood in urine	☐
☐Problem maintaining flow	☐Bladder/kidney stones	☐

Men only		
☐Prostate problems	☐Painful intercourse	Have you ever had a prostate exam? ☐Y ☐N If yes, was it normal? ☐Y ☐N
☐Erectile dysfunction	☐Penile/testicular lumps/ bumps	
☐Penile discharge	☐Other	

Women only		
☐Endometriosis	☐Painful breast	What was date of your last pap smear? Was it normal ☐Y ☐N
☐Fibroids	☐Breast lumps	☐What was the test of your last breast exam Was it normal ☐Y ☐N
☐Ovarian cysts	☐Vaginal discharge	☐Number of pregnancies
☐Painful or irregular periods	☐Uterine/bladder prolapse	☐Number of births

☐Premenstrual tension	☐Intrauterine device/ coil
☐Painful Intercourse	☐Contraception/type?
Are you pregnant, or there is possibility that you are pregnant at present	☐Y ☐N

Nervous system		
☐Panic attacks	☐Depression	☐Twitching muscles /limbs
☐Loss of balance	☐Susceptible to stress	☐Tremor
☐Poor coordination	☐Areas of numbness	☐Slurring speech
☐Dizziness	☐Weak muscles	☐Concussions / blows to head or face
☐Quick temper /irritable	☐Tic	☐Other

How would you rate your stress levels at present?									
No stress								**Extreme Stress**	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

How would you rate your energy levels at present?									
Extreme fatigue								**Normal Energy**	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Comments:
Is there anything else you would like to add?

Informed Consent to Manual Therapy Treatment

Your manual therapist may use manual therapies where his hands are placed on your body. Many techniques will involve contact between your body and the practitioner's body. Body and hand contact may include areas of your chest wall, pelvic floor and pubic bones. If intra-oral work is required, disposable latex or vinyl gloves will be worn. At times, the practitioners may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The techniques can be discontinued or modified to be comfortable for you.

I understand the above and agree to give my consent to the health practitioner for treatment. I hereby give consent to my therapist to treat me with manual therapy, myofascial release techniques, and cranial sacral therapy for the above noted purposes including such assessments, examinations, and techniques, which may be recommended by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that manual therapy 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 understand that in order to provide safe treatment my health practitioner may need to communicate with my physician regarding my condition and treatment. I acknowledge that my therapist must be fully aware of my existing medical conditions. I have completed my medical history as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep my therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers.

Receipts may not be submitted for insurance for Osteopathy unless provided by a DOMP (Diploma of Osteopathy, Manual Practitioner). I understand that Travis Cuddington is currently a student of Osteopathy and is providing treatment within his scope of practice as defined by the British Columbia School of Osteopathic Manual Practice in Vancouver, BC. I understand that A Balanced Approach will collect, use and protect my personal information, which will be kept confidential.

Cancellation Policy

We require a minimum of 24 hours notice for change or cancellation of an appointment. Once an appointment is booked, a treatment time is reserved for you. In order to respect other clients, if you arrive late or need to leave early, you will still be charged the full fee. With the exception of family emergencies or winter road conditions, if you do not contact the office at least 24 hours prior to your scheduled time, you will be charged for the missed appointment.

This cancellation fee is equal to the full fee of the appointment time you have booked.

The above policies are in effect in order to respect all of our clients. We understand that your time is valuable and therefore make every effort to keep our schedule running on time. Due to the nature of our work, unexpected delays sometimes occur. Please be assured that under these circumstances you will receive your full treatment time. Thank you for helping us maintain a high level of service to our clients.

I have read the above noted consent and I have had the opportunity to question the consents 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 treatment as proposed by my therapist from time to time to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand the above and agree to abide by this policy:

_______________________________ _______________________________

Patient Name (Printed) Signature of Patient and/or Guardian

_______________________________ _______________________________

Witness Date Signed