



## Emergency Contact Details

Name

Relationship to yourself

Contact Telephone Number

## Your Doctors Details: -

Name

Practice

Telephone Number

## Your Medical History

Please tick any of the following for which you have been diagnosed or treated by a doctor or health professional?

- Asthma  Heart Problems  Thyroid Disorders  Herpes/shingles   
Diabetes  Multiple Sclerosis  Parkinson's Disease  Fibro/Polymyalgia   
Epilepsy  Glandular Fever  High Blood Pressure  Tuberculosis   
Cancer  Low Blood Pressure  Deep Vein Thrombosis  Hemophilia   
HIV/Aids  Skin Disorders/Infections  Bowel or Bladder Disorders  Impaired Circulation   
Any recent viral or bacterial infection  Mental Health Problems or Depression

Do you have a pacemaker fitted  Yes/No

Do you suffer from allergies?  Yes/No

## Please tick if you ever experience any of the following symptoms: -

- Pain, pressure, heaviness or discomfort in the chest area   
Regular unexplained pain in the abdomen, shoulder, arm, jaw, arms or other areas   
Shortness of breath at rest, during daily activities or with mild exertion   
Dizziness or syncope (fainting)  Sleep apnea  Ankle edema (swelling)   
Palpitations (abnormal rapid beating of the heart) or tachycardia (rapid heartbeat)   
Intermittent claudication (cramping pain and weakness in legs, especially calves during walking)   
Known heart murmur (atypical heart sound indicating a structural or functional abnormality)   
Unusual or unexplained fatigue  Unexplained weight loss   
Night pain or night sweats  Sudden loss of vision  Persistent headaches

Are you presently receiving any sort of therapy or treatment?  Yes/No.

Is there a family history of any of the following conditions? (Refers to biological parents and siblings)

Heart Problems	Yes/No	Diabetes	Yes/No	Epilepsy	Yes/No
Early Menopause	Yes/No	Cancer	Yes/No	Other	Yes/No

Have you had any surgery in the past Yes/No.?

**COVID-19: Have you had the Covid-19 viral infection? YES  NO**   
**To the best of your knowledge, do you feel you are free of symptoms of Covid-19? YES**

**Please be aware I will need to complete a verbal or virtual screen before I am able to provide any face to face treatment or training to reduce risk to you and myself.**

**Prior to attending a face to face appointment , you agree that if you experience any symptoms that may be due to COVID-19 (shortness of breath, continuous cough, unusual fatigue, loss of taste or smell) or may have been exposed to a person with COVID19 you must cancel and reschedule your appointment for 14 days thereafter. Yes / No**

### **Medication, Therapy and Treatment**

Please give details of all medicines taken in the last 6 months and list dosages

### **Ladies**

Are you currently pregnant, been pregnant (including miscarriage and terminated pregnancies) or have you given birth in the last 12 months? Yes/No.

Do you have any problems with periods? Yes/No

If applicable at what age did you reach the menopause?

**If you have answered YES to any of the questions on this form or have any other health problems, please give details below:**

Osteopaths undergo a long period of training and are regulated by the General Osteopathic Council ([www.osteopathy.org.uk](http://www.osteopathy.org.uk)). Training prepares osteopaths to examine and screen for potential difficulties that indicate where certain techniques should not be used, thereby avoiding patients being exposed to unnecessary risk.

Serious side effects are rare. The two most serious risks are:

- 1 - Stroke or artery damage caused to the arteries in the neck.
- 2 - Collapse of a spinal disc causing Cauda Equina Syndrome (damage to the bundle of nerves below the end of the spinal cord that can result in loss of bladder or bowel control)

I hereby confirm that the information given above is correct and undertake to notify **Julia Kinsey** of any changes in my medical condition as soon as I am aware of it. I understand that no personal information will be revealed (to my GP or other) without my written consent.

Client's Signature:

Date:

Printed Name: