JULIA KINSEY
OSTEOPATHY

Osteopathy Health Screening Form

Full Name (including **middle** names) please: -

Title: - Mr/Mrs/Miss/Ms/Dr or other

Please complete in full the following information. This ensures that I am aware of any health concerns and can identify any health issues that may be affected by treatment. Please be aware that I rely on the accuracy of the information given to work safely and effectively with you.

As part of my service to you, I ask for a current email address and mobile phone number in order that I can provide you with text and email reminders of appointments, advice on treatment and sometimes rehabilitation exercises.

My aim is to provide the very best care I can for you.

Your Personal Details: -

Date of Birth / /
Mobile No _____ Home Telephone _____

Work telephone _____

Email address _____ @ _____

How did you hear about the practice? Referral Friend ☐ Referral Family ☐ Internet ☐ Signage ☐ Advert ☐ Event ☐ Referral Other ☐ if other we would really appreciate you letting me know how:

_____

Home address: -

Post code

Your Occupation Employer or Business name

Family – no and age of children

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 ☐

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 ☐

Covid-19 vaccinations: First dose: Date……..…..Type……..…….

Second dose: Date……..……..Type……

Booster Date……Type……

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.?

Medication, Therapy and Treatment
Please give details of all medicines taken in the last 6 months and list dosages

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

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). 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: