Manual Osteopathic Treatment Intake Form

Name: _____

Address:_____

City: _____Province: _____Postal Code:_____

Phone (H):_____ (Bus.): _____(Cell):_____

E-mail:_____

Date of Birth:_____

Occupation:_____ Primary Complaint:_____

How did you hear about us?_____

Please list presence of any internal pins, wires, artificial joints or special equipment:

_____

Please list any allergies: _____

Name of Medical Doctor: _____ Phone:_____

Although you will not be asked to undress for manual osteopathic treatment, please where loose fitting clothing that allows you to move and stretch in order to have the most beneficial treatment.

Financial Agreement:

I agree that I am responsible for all charges relating to my visit. Although many do, I understand that not all extended health care plans cover Manual Osteopathy. I acknowledge that it is my responsibility to determine if my extended health care plan covers Manual Osteopathy prior to treatment.

Cancellation Policy:

I agree and understand that I may be charged for my visit if I fail to cancel my appointment within 24 hours notice or do not arrive for a scheduled appointment.

_____ _____

Signature Date