ELEVATED HEALTH COLLECTIVE

Reset the Form

Personal Information

First Name: _____ Last Name: _____ DOB(YYYY/MM/DD) _____

Address: _____ City: _____ Postal Code: _____

Cellphone: _____ Email: _____ Occupation: _____

Insurance / Extended Healthcare Provider _____

How did you hear about Elevated Health Collective?

☐ Facebook ☐ Instagram ☐ Google ☐ Friends / Family ☐ Other _____

Are you currently receiving treatment from another healthcare provider? ☐ Yes ☐ No

If yes, what type? ☐ Massage ☐ Physiotherapy ☐ Chiropractor

☐ Other _____

Have you had osteopathic treatment in the past? ☐ Yes ☐ No

Which of the following apply to you?

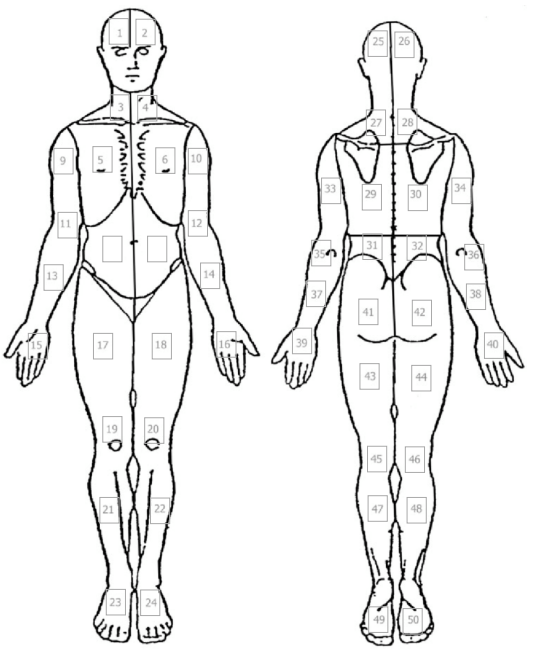
☐ Heart disease ☐ Diabetes

☐ Varicose veins ☐ Infections

☐ Cancer ☐ Past surgeries

Are you currently pregnant? ☐ Yes ☐ No

Indicate where you feel discomfort / pain.



Main complaint(s)

Other complaint(s)

Type of pain _____ **When did it start?** _____

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INFORMED CONSENT TO OSTEOPATHIC MANUAL TREATMENT

I _____ give my full and voluntary consent to osteopathic treatment for the above noted purposes by a qualified osteopathic manual practitioner, within their scope of practice.
The practitioner has thoroughly explained alternative treatment where applicable and relevant, and the possible risks and side-effects of the proposed treatment plan.

I understand that treatments (including assessments, examinations) include manual modalities where the practitioner places his/her hands on my body. If intra-oral work is required, disposable latex or vinyl gloves will be worn.
If you do not feel comfortable with any part of the treatment, please tell me immediately. The techniques can be discontinued or modified to be comfortable for you.

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.

I acknowledge and understand that the osteopathic manual practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my osteopathic manual practitioner and have disclosed to the osteopathic manual practitioner all of those medical conditions affecting me. It is my responsibility to keep the practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

CANCELLATION POLICY

Patients are required to provide a minimum 24 hour notice for any cancellation. That time has been reserved for you and I appreciate having adequate time to fill the spot. The clinic reserves the right to charge the full fee for a missed appointment or an appointment cancelled with less than 24 hour notice. Consideration will be given upon circumstance.
Thank you for respecting my time.

Date _____ Signature _____

Complete if patient is under 18 years old:

Signature _____ Date: _____

Relationship to patient: _____ Contact Number: _____