



Casey Central Osteopathy  
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**New Patient Information Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Post code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Private Health Fund: \_\_\_\_\_

GP Name & Location: \_\_\_\_\_

I consent to Casey Central Osteopathy notifying my GP that I am having Osteopathic treatment (if required).

Emergency contact name & number: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Your occupation: \_\_\_\_\_

**Please fill out this section (if applicable):**

Pension/Concession number: \_\_\_\_\_

Medicare number: \_\_\_\_ \_ Ref No. \_\_\_\_

Department of Veterans' Affairs card number: \_\_\_\_\_

TAC Claim number: \_\_\_\_\_

- Date of accident: \_\_\_\_\_

WorkSafe Claim number: \_\_\_\_\_

- Employer: \_\_\_\_\_

- Date of injury: \_\_\_\_\_

Would you like to opt in to:  SMS reminders  Appointment emails  Newsletter emails

**Privacy policy:** The information that we collect from you allows our Osteopathic Practitioner/s to assess your health and provide you with the utmost care possible. The information will ONLY be used for these purposes in strict adherence to the National Privacy Principles of the State and National Government's privacy legislation. You have the right to obtain access to your health records with Casey Central Osteopathy at any point in time upon request (a small printing fee may be involved).

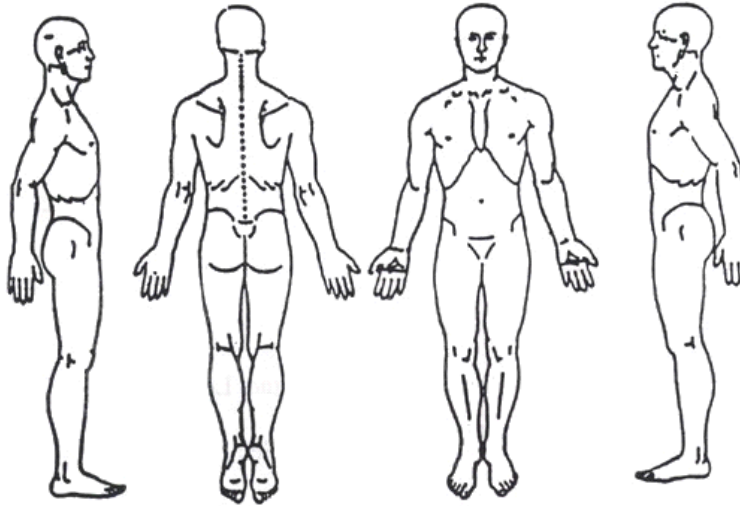
By signing this form I acknowledge that I have given Casey Central Osteopathy consent for the above stated

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

## New Patient Medical History

*Please indicate on the diagram what area you are having assessed/treated today.*



What is the main purpose of your visit today? \_\_\_\_\_

How would you describe what you're feeling? \_\_\_\_\_

Do you experience pins & needles? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

When did you first notice this feeling? \_\_\_\_\_

Have you experienced this before? \_\_\_\_\_

**Please turn over →**

Other professionals seen before in the past:  Osteo  GP  Physio  Chiro  Massage  Specialist

Others *(Please list):* \_\_\_\_\_

Any investigations or tests?  X-rays  Ultrasound  MRI scan  CT scan  Bloods  Other/s

List any medications & supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had or have had any of the following? *(please tick)*

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> High/Low Blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clot      | <input type="checkbox"/> Breathing issues |
| <input type="checkbox"/> Pins & needles          | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Migraines     | <input type="checkbox"/> GIT issues      | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Rheumatoid Arthritis    | <input type="checkbox"/> Osteoarthritis   | <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Muscular injury | <input type="checkbox"/> Joint injury     |
| <input type="checkbox"/> Ligament injury         | <input type="checkbox"/> Disc problems    | <input type="checkbox"/> Fracture      | <input type="checkbox"/> Surgery         | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Trauma/Accident         | <input type="checkbox"/> Major infection  | <input type="checkbox"/> Incontinence  | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Pregnancy        |

Is there anything else you believe you need to inform your Osteopathic practitioner?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Minor Osteopathic informed consent**

Osteopathy is a recognised manual therapy for the care of many musculoskeletal related conditions. However, much like anything you must recognise that there are slight risks associated with all health care procedures or treatments. This includes Osteopathic Manual Techniques, which you must be informed about. All of our Practitioners are registered with the Australian Health Practitioner Regulation Agency (APHRA). Our philosophy is to look at the body as ONE WHOLE UNIT to find the primary source of your problem. Our Osteopathic Practitioners will aim to help you understand what your body is going through so that you will leave with a better knowledge about what your body's limitations are and how to prevent and manage your problem down the track.

### Normal treatment effects:

The initial 24-48 hours after an Osteopathic treatment you may experience mild temporary post-treatment soreness. There may also be temporary exacerbation of your symptoms or underlying condition. Please be advised that this is considered to be normal, as your body is responding to the treatment.

As part of your Osteopathic treatment, your treating practitioner may also use other treatment techniques and adjuncts stated below. Please kindly indicate by ticking the boxes below if you would like to consent to have these treatment techniques and adjuncts as part of your treatment; *\*Please fill out additional consent forms for each treatment technique/adjunct, thank you.*

- Neck and spinal manipulation
- Superficial dry needling
- Myofascial cupping
- Shockwave therapy

I have had the opportunity to discuss the proposed care with my Practitioner below. I have disclosed all relevant health and medical information. I also acknowledge that I have had the opportunity to question the nature, extent and purpose of care of my Osteopathic treatment. I understand that I can withdraw consent to treatment at any time.

Our Privacy Statement sets out the policy of Casey Central Osteopathy with respect to the way in which we collect, use, disclose, store, secure and dispose of Personal Information about our patients. The information that we collect from you allows our Practitioner/s to assess your health and provide you with the utmost care possible. The information will ONLY be used for these purposes in strict adherence to the National Privacy Principles of the State and National Government's privacy legislation.

I confirm that I have read and understood ALL the information above; I hereby acknowledge my consent to the proposed Osteopathic care by the treating practitioner below.

**Patient name:** \_\_\_\_\_

**Guardian name:** \_\_\_\_\_

**Osteopaths name:** \_\_\_\_\_

**Dated:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Guardian signature:** \_\_\_\_\_

**Osteopaths signature:** \_\_\_\_\_