



Jocelyne Heyton, D.O.M.P.

541 Palace Road Kingston, ON K7L 4T6  
613.547.KIHC (5442)  
www.kihc.ca

### OSTEOPATHIC HEALTH INFORMATION

*Every detail you provide will help you achieve your health goals and will remain confidential. Please bring this completed form to your first appointment.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth (dd/mm/yy): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_

What is the best way for us to contact you? \_\_\_\_\_

May we leave telephone messages at home or work? \_\_\_\_\_

Would you like to receive our clinic email newsletter? \_\_\_\_\_

How did you hear about this health practice? \_\_\_\_\_  
\_\_\_\_\_

Please list all other healthcare practitioners you receive care from, including your dentist:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

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

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

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Present Conditions: Why have you come, what's bothering you now?

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



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Please list your primary health concerns, in order of importance:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_
2. \_\_\_\_\_ Date of onset: \_\_\_\_\_
3. \_\_\_\_\_ Date of onset: \_\_\_\_\_
4. \_\_\_\_\_ Date of onset: \_\_\_\_\_

Do you have any other health concerns? \_\_\_\_\_

## MEDICAL HISTORY

Please list any hospitalizations, surgeries (including dental), traumas (including emotional traumas) or major illnesses:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
5. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_

Please list any **medications** you are taking, including antacids, pain medications, and laxatives:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_

## MOTOR VEHICLE ACCIDENT

Have you ever been in a motor vehicle accident? \_\_\_\_\_

Where/When/How? \_\_\_\_\_

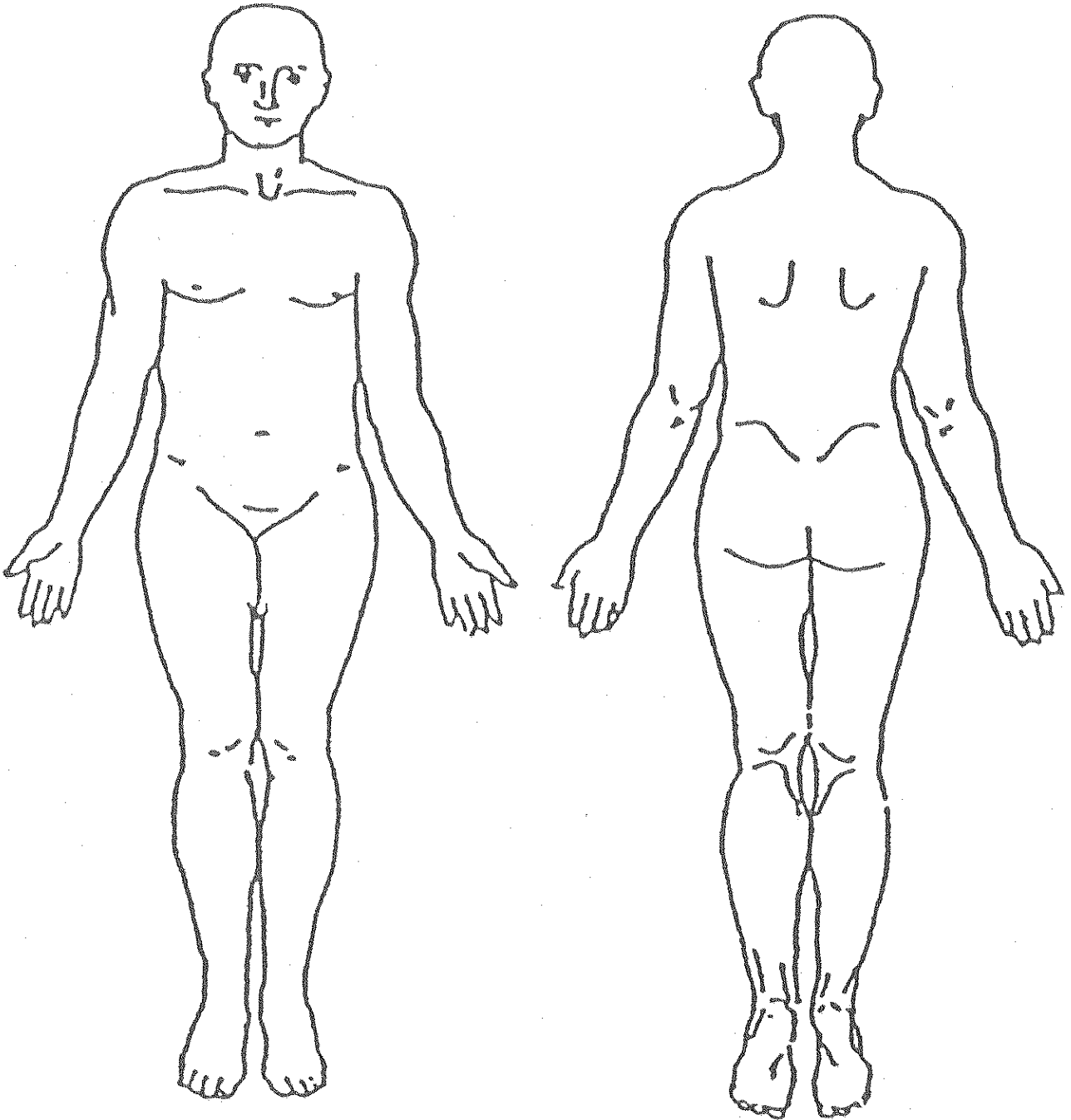
Driver or Passenger? (Please circle) Were you wearing a seatbelt? Yes \_\_\_\_\_ No \_\_\_\_\_

What was the speed at impact? \_\_\_\_\_ Was anyone else in the vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

Where were you hit? Front \_\_\_\_\_ Back \_\_\_\_\_ Side \_\_\_\_\_ Diagonal \_\_\_\_\_

Related problems: \_\_\_\_\_

Please draw on the diagram where you have symptoms:





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## DETAILED HEALTH HISTORY

Please put an "X" beside any conditions presently causing you problems. Please circle any condition which has been a problem in the past.

### GENERAL HISTORY

Headaches - When?  
How often?  
AM/PM  
Migraines - When?  
How often?  
Fainting  
Fatigue  
Nervousness  
Rashes, Irritations  
Specific infections  
Susceptible to colds or  
infections  
Fever  
Insomnia  
Allergies  
Cancer  
Fibromyalgia  
Coldness in extremities  
Arthritis  
Osteoporosis

### NERVOUS SYSTEM

Numbness/Tingling  
Convulsions (or related  
conditions e.g. seizures)

### MUSCULAR-SKELETAL SYSTEM

Neck pain/Head pain  
Whiplash  
Sprains  
Fractures  
Falls  
Joint pain Location: \_\_\_\_\_  
Joint swelling Location: \_\_\_\_  
Knee pain  
Ankle pain  
Carpal tunnel  
Tennis elbow  
Backache

### RESPIRATORY SYSTEM

Chronic cough  
Shortness of breath  
Pneumo-thorax  
Presence of phlegm  
Pneumonia  
Bronchitis/Asthma/Emphysema

Chronic obstructive pulmonary  
disease (COPD)

### CARDIOVASCULAR SYSTEM

High/low blood pressure  
Heart attack  
Chest pain  
Angina  
Arteriosclerosis  
Varicose veins/phlebitis  
Stroke  
Aneurysm  
Congestive heart failure

### SPECIAL SENSES - EYES, EARS, NOSE & THROAT

**Eyes**  
Surgery  
Distorted vision  
Glaucoma  
Sensitive eyes

#### Ears

Infection  
Dizziness  
Ringing in ears

#### Nose

Surgery  
Septal deviation  
Trauma  
Breathe easily  
Sinus problems  
Sinusitis

#### Throat

Trouble swallowing

#### TMJ

Jaw pain  
Facial pain  
Dental surgery  
Mouth infections  
Clicking or locking jaw  
Restricted opening of jaw

### URINARY SYSTEM

Bladder infection/dysfunction  
Yeast infection

Kidney infection  
Kidney disease  
Diabetes  
Urinate frequently  
Difficulty urinating  
Incontinence  
Rectal bleeding

### GASTRO-INTESTINAL SYSTEM

Loss of weight  
Poor appetite  
Ulcer  
Gas, bloating  
Vomiting  
Pain over stomach before  
eating/after eating  
Constipation  
Diarrhea  
Irritable bowel syndrome  
Reflux  
Colitis  
Hemorrhoids  
Nausea  
Indigestion  
Excessive hunger  
Hiatal hernia

### REPRODUCTIVE SYSTEM

Prostate  
Erectile dysfunction  
Sexually transmitted diseases  
Infertility

#### Pregnancies

Number of pregnancies \_\_\_\_\_  
Abortions \_\_\_\_\_  
Miscarriages \_\_\_\_\_  
Deliveries \_\_\_\_\_

- Labour  
 Epidural  
 Forceps

#### Menses

- Regular  
 Pain  
 Medications  
 PMS



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X Rays: \_\_\_\_\_

CAT scan: \_\_\_\_\_

MRI: \_\_\_\_\_

Are you receiving any treatment now? \_\_\_\_\_

\_\_\_\_\_

## EMOTIONAL HEALTH

What do you do to relax? \_\_\_\_\_

On a scale of 1 (low) to 10 (high), how would you rate your overall stress level? \_\_\_\_\_

On a scale of 1 (low) to 10 (high), how would you rate your overall energy level? \_\_\_\_\_

Do you have any concerns regarding your emotional or mental health (please describe)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any other concerns that you feel a therapist should know about? Yes / No

Explain: \_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like to include on this form? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Thank you*



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## INFORMED CONSENT FOR TREATMENT

Osteopathy is a manual therapy where the health practitioner places his or her hands on your body. Body and hand contact may include areas of your anterior chest wall, pelvis, pelvic floor, pubic bones and the face and internal mouth work. If you do not feel comfortable with any given technique, please tell the therapist **immediately**. The technique will be discontinued or modified to be comfortable for you.

The Ontario Government prefers patients to give consent for treatment in writing. By signing this consent form you acknowledge that you consent to treatment and have had your questions about treatment answered to your satisfaction.

### Statement of Acknowledgement

I understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side-effects. I am entitled to know the consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I am aware that I am free to withdraw my consent and discontinue treatment at any time. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

I accept full responsibility for any fees incurred during care and treatment. I understand that 24 hours' notice is required to cancel an appointment or I will be responsible for the full cost of the appointment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS



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## CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern and the personal health information you disclose to Jocelyne Leyton during your appointments will be handled in accordance with current privacy legislation. Personal health information includes identifiable information such as name, address, age, gender, family status, and health history.

Jocelyne Leyton, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information. They will not have access to your written health file which is retained by Jocelyne Leyton, except with your express permission. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

Do you give permission for communication between Jocelyne Leyton and:

Your referring health care professional? \_\_\_\_\_

Your family doctor? \_\_\_\_\_

Another individual or group? (If so, please list their names and relationship to you): \_\_\_\_\_

You have the right to withdraw your consent for communication to any of the above listed persons at any time.

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I have reviewed the above information and authorize Jocelyne Leyton, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS