Dear New Patient,

Thank you for your interest in Osteopathy. You have just taken an important step towards optimizing your body and overall health. It is essential during the treatment process that you remember to be patient with your body, as is it may take several appointments to notice significant improvements within the body.

Please fill out these new patient forms and bring them to your first visit. These forms include the systems review, and a consent form. Please note that the intake form asks for your email address. With your consent, this will be used only for the purposes of electronic appointment reminders as well as periodic patient emails regarding relevant health and office information. The information you share on the intake and during all appointments will be kept confidential and will not be shared with anyone else, unless your written consent is given to do so.

The first visit will be approximately 60 minutes in length where we will discuss what injury or ailment you are seeking treatment for. The appointment will also involve taking a detailed health history including reviewing past injuries that can often play a large role in present issues you may be experiencing. Please wear loose fitting comfortable clothing to the appointment and be prepared that you may receive hands on treatment within your first visit. Along with hands on treatment plans our Osteopath team also uses modalities such as: Laser, Deep Oscillation, FSM and Vibrocussor to enhance your healing process. You will leave your first appointment with a clear treatment plan that includes detailed follow up instructions. Subsequent follow up visits are typically weekly or biweekly after the initial visit, lasting approximately 4-6 weeks. The optimal treatment plan will differ with every patient and condition being treated; your specific treatment plan will be discussed with you at your visit.

Please note that payment is due at the end of your visit. For your convenience we accept Visa, Mastercard, Debit, cash and cheque. If you are unable to make a scheduled appointment, please give at least 24 hrs notice, so that time can be made available to another patient. If less than 24hrs notice is given, you will be charged the full appointment fee for the scheduled visit.

Maple Shores Health Centre is located at the northwest corner of Goderich Street (Hwy 21) and Mill Street. Free street parking is available on all of the downtown streets. There is also a free public parking lot off of Elgin Street (one street north of Mill Street), behind the Port Elgin Library, that is a short walk to the clinic.

If at any time you have questions or concerns about your treatment, please feel free to voice them during your visits, or contact the office at (519) 832-4500. I look forward to working together with you to help you enjoy long lasting health improvements.

Yours in health,

Danielle Henry, DOMP
Kinesiologist and Osteopath

MAPLE SHORES HEALTH CENTRE

Child Intake

Child's Name:_____ Date of Birth: _____ Age: _____ Gender: ☐M ☐F

Who is filling out this form? Name: _____ Relationship to child: _____

Contacts (in order of preference)

1. Name: _____ Home Phone: _____ Work: _____

Address:_____ City:_____ Postal Code:_____

Email:_____ *Do you consent for your email to be used for the purposes of appointment reminders and occasional emails regarding relevant office and/or health information? You may contact the office at any time to withdraw your consent.* ☐ ***YES*** ☐ ***NO***

Relationship to Child: _____

2. Name: _____ Home Phone: _____ Work: _____

Address (if different than above):_____City:_____ Postal Code:_____

Relationship to Child: _____

Whom does the child live with? _____

Other health care providers:

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

How did you hear about Maple Shores Health Centre or the practitioner?: _____

THIS IS A CONFIDENTIAL MEDICAL RECORD AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT FOLLOWING APPROPRIATE WRITTEN AUTHORIZATION.

What are your child's health concerns, in order of importance?

1. _____

2. _____

3. _____

Has your child seen any specialists? Yes No If yes, please indicate name of doctor and year of visit.

_____

_____

Please indicate any serious conditions, illnesses, injuries, and/or any hospitalizations you child has experienced, along with approximate dates: _____

_____

_____

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MAPLE SHORES HEALTH CENTRE

MEDICAL HISTORY:

Please list all **CURRENT prescribed medications your child is taking**.

Medication	Dose	How long taken	Reason for Use

How many times has your child been treated with antibiotics? _____

Please list any **over the counter medications your child is presently taking** (e.g. Aspirin, Tums).

Medication	Dose	How long/often taken	Reason for Use

Please list any **vitamins/minerals, herbs or homeopathic remedies that your child takes on a regular basis**:

Supplement	Dose	How long taken	Reason for Use

Please list all sensitivities/allergies/reactions to the following:

Drugs:_____

Environment:_____

Food:_____

Immunizations (please check):

- ☐ Flu Shot
- ☐ Diptheria/Pertussis/Tetanus
- ☐ Measles/Mumps/Rubella
- ☐ Haemophilus Influenza
- ☐ Chicken Pox
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B

Describe any adverse reactions: _____

Has your child had any of the above diseases? If so, which one(s): _____

Which of the following diseases has your child had?

- ☐ Roseola
- ☐ Impetigo
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Mononucleosis

Has your child had any of the following tested?

Hearing Tests ☐ YES ☐ NO Vision Tests ☐ YES ☐ NO

Speech ☐ YES ☐ NO Learning Disorder ☐ YES ☐ NO

If yes, please provide details if there were any concerns identified in the testing?_____

_____

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Please check if your child has had any of these concerns:

- ☐ Jaundice as Baby
- ☐ Cradle Cap
- ☐ Eczema or Psoriasis
- ☐ Constipation
- ☐ Finicky Eating
- ☐ Poor Teeth/Cavities
- ☐ Night Terrors/Nightmares
- ☐ Frequent Colds/Sniffles
- ☐ Overly Shy/Social Problems
- ☐ Overweight/Obese
- ☐ Colic
- ☐ Anemia (low iron)
- ☐ Diarrhea
- ☐ Asthma
- ☐ Warts
- ☐ Bed-wetting
- ☐ Tantrums
- ☐ Disobedient
- ☐ Lethargic/Low Energy
- ☐ Diaper Rash
- ☐ Hyperactive/Impulsive
- ☐ Growing Pains/Leg cramps
- ☐ Stomach Aches
- ☐ Fears/Phobias
- ☐ Acne
- ☐ Attention Deficit
- ☐ Ear Infections
- ☐ Has Issues with his/her Appearance
- ☐ Cognitive Problems
- ☐ Strep Throat

Please provide more details, if applicable, if you checked off any of the items above: _____

_____

_____

FAMILY MEDICAL HISTORY:

Relation	Current Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Siblings			

PRENATAL HEALTH:

What was the health of the parents at conception?

Mother ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Father ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

What was the mother's age at the child's birth? _____

How was the mother's diet during pregnancy? Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown ☐

Did the mother receive prenatal medical care? Yes ☐ No ☐ Unknown ☐

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ Diabetes ☐ High Blood Pressure ☐ Nausea

☐ Vomiting ☐ Thyroid Problems ☐ Physical/ emotional trauma

Other: _____

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Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements:_____

BIRTH HISTORY:

Pregnancy Length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

Type of birth: ☐ Vaginal ☐ C-section

Types of Intervention: ☐ Induced labour ☐ Use of forceps ☐ Epidural/anesthesia
☐ Other:_____

Length of Labour: _____ Birth Weight: _____

If the birth was difficult, please explain _____

Did the child experience any of the following at, or shortly after, birth?
☐ Jaundice ☐ Seizures ☐ Colic ☐ Respiratory Difficulties: _____
☐ Birth injuries: _____ ☐ Birth defects: _____
☐ Skin Disorders: _____ ☐ Other: _____

FEEDING HISTORY:

How was your child fed as an infant?
☐ Breast fed: How long? _____ ☐ Formula: Milk / Soy / Other: _____
Please describe any reactions you observed: _____

When was your child first introduced to solid foods, and in what order? _____

_____

If any adverse reactions were noticed, what were they? _____

Please describe a typical day's diet:
Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (and total quantity): _____

What are your child's favourite foods? _____

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What foods does your child strongly dislike?: _____

How much of your food is organic? _____

Is your family's diet: ☐ Omnivore ☐ Vegan ☐ Vegetarian ☐ Other (please define):

Does your child drink caffeine (i.e. pop, tea)? ☐ YES ☐ NO Type: _____ Frequency: _____

HEALTH AND DEVELOPMENT:

How was your child's health in the first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

At what age did your child first:
Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

Is your child in: ☐ school ☐ daycare ☐ homecare ☐ other: _____

If so, how many times a week and for how long? _____

Who spends the most time caring for your child? _____

Child is: Oldest ☐ Middle ☐ Youngest ☐ Only ☐ # Sisters: _____ # Brothers: _____

What are your child's favourite activities? _____

_____

How many hours of sleep does your child get per night? _____

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, waking up, etc.)? _____

Does your child exercise regularly? Yes ☐ No ☐ How much and how often? _____

How much screen time (TV, tablet, computer) does your child usually get? _____ hrs per day

Is your child exposed to second hand smoke? ☐ YES ☐ NO Where?

Is your child frequently exposed to animals? ☐ YES ☐ NO What type? _____

Do any animals sleep with your child? ☐ YES ☐ NO

Does your child interact well with family members & other children? YES ☐ NO ☐

Who, if any person, does your child struggle to act well with? _____

Has your child experienced any bullying at school? YES ☐ NO ☐

What, if any, are the most challenging behaviors you face with your child? _____

_____

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What reward system do you have in place for your child? _____

What are the preferred methods of discipline/correction in your home by each parent? _____
_____

How is your child doing at school? _____

Any particular household stressors that your child has witnessed or gone through?
1._____
2._____
3._____

ENVIRONMENTAL TOXIN EXPOSURE

Has your child ever lived near a refinery or other highly polluted area? _____

Has your child ever lived in a house with lead paint? _____

Has your child ever lived in a house during renovations (i.e. new paint, cabinets, carpeting, etc ? YES☐ NO☐
Did that seem to affect his/her health at all? _____

Do you spray pesticides or herbicides around or in the house, or use other toxic chemicals? _____

Does your child seem sensitive to perfumes, scented products or other odours? _____

Please list any other relevant health/ personal information that you feel is missing: _____
_____
_____
_____

Thank you for choosing the Maple Shores Health Centre for your health care needs.
Helping you live better…now and into the future

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MAPLE SHORES HEALTH CENTRE

INFORMED CONSENT

I would like to take this opportunity to welcome you to Maple Shores Health Centre. Danielle Henry utilizes the principles and practices of Osteopathy (D.O.M.P.), as well as other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. A number of different approaches may be used addressing different areas of the body; Muscle energy technique(s), visceral manipulation, craniosacral, lymphatic system, soft tissue treatment, and myofascial release. Other modalities may include low level laser, micro current and recommended home exercises.

Statement of Acknowledgement

Printed name _____

As a patient of this clinic, I understand that the form of medical care is based on D.O.M.P and other supportive principles and practices. I recognize that even the gentlest therapies have potential complications in conditions such as diabetes, heart, liver or kidney disease, during pregnancy and lactation. Therefore, it is very important that the information provided is complete and inclusive of all health concerns including risk of pregnancy and all medications being used simultaneously, including prescribed medications, over the counter drugs, herbs and nutritional supplements. The slight health risks of some D.O.M.P treatments include, but are not limited to: aggravation of pre-existing symptoms or conditions, allergic reaction to supplements or herbs and pain, headache, fainting, bruising or injury.
As a patient of Danielle Henry, D.O.M.P, I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario. This consent form is intended to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that results are not guaranteed. I understand that treatment advice will not be given over the phone or via e-mail unless directly relating to specifics discussed during a clinic visit. I accept full responsibility for any fees incurred during care and treatment. I also understand that the Maple Shores Health Centre cancellation policy requires me to cancel and/or reschedule a booked appointment 24 hours prior to a given, scheduled appointment. Failure to do so will incur full fees for the missed appointment that must be paid prior to the next visit.

I have read and completed the intake form and stated all medical condition that applies to me to the best of my knowledge. I will notify the massage therapist of any changes in my health status to ensure my safety for receiving massage. I acknowledge that these massage treatments are not a substitute for medical examination or diagnosis, and that this is recommended that I see a Medical Doctor for that service.

_____	_____	_____
SIGNATURE	DATE	WITNESS

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