Christian Lutz OSTEOPATHY

NEW PATIENT FORM

Name _____ Date of birth _____

Address _____ Occupation _____

_____ Employer _____

State _____ Postcode _____ Email _____

Phone (M) _____ Referred by _____

(H) _____

Where did you hear about Christian Lutz Osteopathy? _____

(ie referral from family/friend, referral from practitioner/doctor, advertisement, social media, walk in, website or other)

What is the main purpose of your visit today? _____

_____

Have you been to an Osteopath previously? ☐ yes ☐ no

If so, what for? _____

_____

Do you have any existing medical conditions? _____

_____

List any injuries, accidents, operations; _____

_____

_____

List any medications or supplements you are currently taking; _____

_____

Do you suffer or have suffered from any of the following?

High or low blood pressure	☐ yes	☐ no	Breathing difficulty	☐ yes	☐ no
Stroke	☐ yes	☐ no	Skin conditions	☐ yes	☐ no
Headaches, migraines	☐ yes	☐ no	Allergies	☐ yes	☐ no
Cancer	☐ yes	☐ no	Digestive problems	☐ yes	☐ no

Further details _____

_____

Do you smoke? ☐ yes ☐ no Are you pregnant? ☐ yes ☐ no

List your sports, exercise activities; _____

_____

GP Name: _____ GP Phone: _____

GP Address/Suburb: _____

PATIENT INFORMATION (0 - 2years)

Christian Lutz OSTEOPATHY

What is your reason for attending the clinic?

_____

_____

Have you seen any other health care practitioners for these problems? ☐ yes ☐ no

If so, whom?_____. When was your child last seen & what were the results of treatment?

_____

Is your child under the care of any other health care practitioners? _____

_____

Length of pregnancy: _____

Please tick the relevant:

☐ Hospital Birth ☐ Home Birth ☐ Vaginal Delivery ☐ Caesarean ☐ Epidural Induction

☐ Forceps/Vacuum ☐ Breech Position ☐ Jaundice ☐ Meconium ☐ Antibiotics (Mother/Baby)

Did the child get stuck in the birth canal? _____. If yes, please explain: _____

_____

Did the child have any bruising after birth? _____. If yes, please explain: _____

_____

Please explain any other events/complications during pregnancy or birth: _____

_____

Natural or Assisted Conception (e.g. IVF)? _____

Please describe the mother's health during pregnancy, and if any of the following occurred/was used/was a factor (Nausea, Over the Counter Medicines, Alcohol Consumption, Prescription Medicines, Bleeding, Physical / Emotional Trauma, Recreational Drugs, Depression, Supplements, Diabetes, Smoking, Exercise, Stress, Illness, Other): _____

_____

_____

_____

Please describe the child's health in the first month, and if any of the following occurred and how often (Coughing / Wheezing, Frequent Infections, Ear Infections, Colic, Reflux / Vomiting, Constipation / Diarrhoea, Heart Murmur, Anaemia, Eczema, Thrush, Epilepsy / Seizures):_____

_____

_____

_____

Describe your child's appetite (and any known food allergies): _____

_____

Has the child had any of the following and if so, please state the time: (Chicken Pox, Measles, Whooping Cough, Pneumonia, Rubella, Other): _____

_____

Please tick the relevant in regards to immunisations:

☐ Vaccinations to Schedule ☐ Selective Vaccination ☐ Conscientious Objector

Please describe your child's sleep patterns: _____

Day sleeps: _____ Night sleeps: _____

Christian Lutz
OSTEOPATHY

Osteopathic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks with all health care procedures, which you should be informed about. All practitioners who use Osteopathic Manipulative Treatments on a patient are required to warn patients of the possible risks associated with those procedures. In very rare circumstances, some treatments of the neck may damage blood vessels and even give rise to stroke like symptoms. *(It is believed the risk may be approx. 1-2 strokes per 1,000,000 neck manipulations performed).*

Please read the following carefully;

1. It has been explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I acknowledge that I have discussed with my Osteopath the rare risks associated with my treatment which include but are not limited to muscle and joint soreness or strains, nausea, dizziness, fractures, disc injuries, strokes (or like episodes), dislocation, bleeding, bruising, inflammation and an exacerbation or aggravation of my underlying condition.
2. I have had the opportunity to discuss the proposed care with the osteopath (named below); I have disclosed all relevant health information. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed care and other alternative treatments and been given sufficient time to make a decision giving consent for the care to proceed.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that a result cannot be guaranteed.
4. I do not expect the Osteopath to be able to anticipate every potential risk and complication associated with the proposed treatment/procedure.
5. I hereby acknowledge my consent to the performance of the proposed Osteopathic care by the osteopath below. I understand that I can withdraw consent at any time in writing and that this consent form does not encompass the entire discussion I had with the Osteopath regarding proposed treatment.

Patients name..... Patients Signature.....

Osteopaths name..... Osteopaths Signature.....

Dated.....