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 (2 – 12 years)

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? ____

____

Please indicate any problems below:

☐ yes ☐ no Nerve, Muscle, Bone, Joint Problems e.g. growing pains, headaches: ___________________________

☐ yes ☐ no Heart, Lungs, Respiratory, Circulation Problems, e.g. asthma: _________________________________

☐ yes ☐ no Eyes, Ears, Nose, Throat Problems, e.g. ear infections, recurring colds/coughs: __________________

☐ yes ☐ no Kidney, Bladder, Urinary or Genital Problems, e.g. Bedwetting, constipation: ______________________

☐ yes ☐ no Endocrine/hormonal Problems, e.g. Thyroid, diabetes: ____

☐ yes ☐ no Behavioural/Developmental Delay: ____

☐ yes ☐ no Mood or Stress disorder, e.g. Depression, Anxiety: ____

☐ yes ☐ no Bowel, Digestive Issues, e.g. Constipation, diarrhoea, reflux, Crohns, Collitis, IBS: _________________

Describe any previous (or future) surgery or hospitalisations your child has or has booked: ____________________________

____

What x-rays, CT Scans or other medical test have been taken in their lifetime? ______________________________________

____

What accidents have they had in their lifetime (e.g. car, or sporting related)?____

____

What illnesses has your child previously had? ____

____

Does your child wear shoe inserts/orthotics? ____

Is/has your child had any major dental work done (ie. tooth extraction, braces, plates etc)? Please describe ____________

____

How would you rate your child's physical health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

How would you rate your child's general mood and/or emotional/mental wellbeing?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

Does your child have trouble going to sleep or staying asleep? ☐ yes ☐ no, if so, please explain _____________________

____

Does your child have difficulty feeding/eating? ☐ yes ☐ no, if so, please explain _________________________________

____

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……………………………………….