1229 King Rd E,
King City, ON L7B 1K5
647-503-3362
info@drewosteopathy.ca
53 Front St
Sioux Lookout, ON
Mail: 2 Hannah Crescent
Sioux Lookout, ON
P8T 1G8

On January 1, 2004 the Personal Information Protection and Electronic Documents Act (the Act) came into effect with a mandate to balance the privacy rights of the individual and the needs of commercial organizations to collect information for business purposes.

Drew Osteopathy remains committed to you, your health and respects your right to confidentiality. The privacy policy of Drew Osteopathy is founded on the following principles:

Accountability
Drew Osteopathy (DO) is responsible for maintaining and protecting all information collected by the clinic. Tara Drew is the Privacy Officer for DO and will address any of your inquiries. Please contact Tara at: Info@Drewosteopathy.ca, 647-503-3362 in King City, or 807-700-1600 in Sioux Lookout.

Limited and Accurate Collection of Information
DO limits the collection of personal information to that which is necessary for the provision of excellent health care. This information is accurately maintained in its most current form in order to fulfill the purposes for which it was collected.

Consent
A decision to receive care at DO implies consent for the sharing of information internally, for purposes related to your health care only. Written consent is required from you in order to share your health care information externally. You may withdraw this consent in writing at any time.

Disclosure and Retention
Patient information is kept in a secure manner for a period of 10 years. This information will only be utilized for the purposes for which it was collected or if required by law.

Information Storage
Appropriate security measures are utilized to secure the privacy of all information collected in the delivery of your health care services.

Patient Access
You are entitled to view the information collected by DO regarding yourself. You may obtain a copy of your records. There is a fee for this service.

I hereby consent to the collection, use, maintenance and disclosure of my personal information as indicated above, unless and until I advise otherwise in writing.

Date	Name	Signature	Witness

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RELEASE OF INFORMATION, INFORMATION COLLECTION, ASSESSMENT, AND TREATMENT CONSENT FORM

I, _____, authorize Drew Osteopathy
Name of Guardian/Patient

[ ] to collect and store _____'s personal information
(initials) Patient's name
to be used solely treatment record purposes.

[ ] to assess and treat _____ having been informed of
(initials) Patient's name
the assessment procedure and treatment proposed. By signing this form you acknowledge that you consent to an assessment and treatment and have had your questions about treatment answered to your satisfaction. Osteopathy and Physiotherapy include a variety of manual techniques where the physical therapist/osteopathic manual practitioner will place his/her hands on your body. Body and hand contact may include areas of your anterior chest wall, abdomen, tailbone, pelvic floor and pubic bones. Intraoral palpation may also be required, for which a glove will be worn.

For assessment and treatment, please wear loose fitting clothing. You need only disrobe to the level that you are comfortable. If you do not feel comfortable with a given technique, please indicate that to the practitioner. An explanation will be provided as to the risks and benefits of the technique. An explanation of the mechanical and physiological occurrences will be provided. The technique will be modified or discontinued based upon your consent.

[ ] to provide information, opinions, notes and reports to
(initials)

_____
Name(s) of practitioners/people and addresses
which they may request regarding the condition and treatment of

_____, and any documents related to this condition.
(condition/ailment/diagnosis)/patient

[ ] to receive pertinent medical information regarding my condition for which I am
(initials)
being treated, from other health practitioners _____.

I have the right to withdraw consent at any time either verbally or in written format.

_____ _____
signature date

_____
Parent/Guardian (please print)

_____ _____ _____
Witness signature date Witness (please print)

Drew Osteopathy

Medical History Questionnaire

Name: _____ Date of Birth: _____

Address: _____

Phone: (h)_____(w)_____ Email: _____

This form is designed to provide as much information regarding your history as possible so as to maximize the amount of treatment time available on your appointment day. This questionnaire takes into account your whole life, starting from birth to present. When possible, please provide dates and explanations. Please use additional paper as necessary.

1. Medications: Please list all medications, vitamins, supplements

_____

_____

2. Investigations: X-rays, CTScans, MRIs, EMGs, U/S, within the last 5 years or significant findings.

_____

_____

_____

_____

3. Chief Complaint: reason for appointment

_____

_____

_____

4. Secondary complaints: what else is bothering you

_____

_____

_____

_____

5. History of present illness: was there a specific injury or did it come on on its own? When did it start?

_____
_____
_____

Is it getting better or worse or not changing? _____
Is the pain local or does it go into a leg or arm – try to describe as exact as you can.

_____
_____
_____
_____

What kind of pain is it – sharp/dull/burning/achey/stabbing/shooting?
What makes it worse—movement/rest/specific activity?
What makes it better?

_____
_____
_____

6. What treatment have you had so far? Is it making a change?

_____
_____

7. Personal birth history: Were there any complications, long/fast labour, forceps/ suction/c-section?

_____
_____
_____

8. Surgeries: any kind at any time: tonsils, gall bladder, etc.

_____
_____
_____

9. Cancers: _____

10. Medical problems: diabetes/high blood pressure/cardiac problems/neurological

_____
_____
_____

11. Fractures: At any time

_____
_____
_____

12. Motor vehicle Accidents

_____
_____

13. Falls – on ice, down stairs, out of trees ….

14. Head Injuries – loss of consciousness, concussions, stitches

15. Musculoskeletal injuries: sprains, strains, dislocations, back/neck pain

16. Headaches: history of migraines/severe headaches/tension headaches/TMJ

17. Eyes: when last checked/any changes/eye diseases

18. Ear/Nose/Throat: any history of infections as a child, ear tubes, sinusitis, strep throat

19. Dental: braces/extractions/fillings/plates/bridges/root canals/TMJ

20. TMJ: clicking/locking/unable to open/unable to close/grinding/
pain with chewing/ear pain/headaches

21. Respiratory: pneumonia/bronchitis/asthma/smoker

22. Cardiac: any heart problems

23. Digestion: mono/hepatitis/jaundice/bloating/indigestion/heart burn/constipation/diarrhea/ irritation after eating

24. Urogenital: bladder/kidney infections/stress incontinence/urinary frequency/retention/ menstrual problems—cramping/bloating/back pain/menopausal
pregnancies/deliveries/C-sections/epidurals
prostate—PSA results/urinary frequency/retention

25. Sleep: any difficulties getting to sleep, staying asleep, any specific time wake in night, wake rested

26. Stressors:

Anything else that you think is related or important:

Please bring to appointment or email to info@drewosteopathy.ca