Fulcrum
MANUAL THERAPIES INC

JOSH SCHELLENBERG
OSTEOPATHIC MANUAL THERAPIST
RMT., D.O.M.P., D.Sc.O.
153 ROCKRIDGE DR, UNIT #103
(431)-996-3929

PATIENT HISTORY - PLEASE FILL OUT PRIOR TO FIRST VISIT.

Date: (DD/MM/YYYY) _____

Full Name: _____ Birth Date: _____

Your Address: _____

Cell Phone: _____ Family Doctor: _____

Emergency Contact & Number: _____

Your Current Employment: _____

How did you hear about Fulcrum Manual Therapy? _____

Describe any physical symptoms you are experiencing or the reason(s) for today's visit:

1. _____
2. _____
3. _____
4. _____

MEDICAL INFORMATION

Medications: _____

Diagnosed medical conditions: _____

Family medical history (genetic / hereditary conditions)

_____

_____

Please CIRCLE if you have had any of the following procedures at any point in time:

MEDICAL ULTRASOUND X-RAY SURGERY MEDICAL SCOPE MR CT SCAN

List any other medical procedures you have received and their findings:

_____

_____

_____

List any past bodily traumas and dates, from childhood to present -anything as far back as you can remember.

_____

_____

_____

_____

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LIFESTYLE INFORMATION

Sleep: (average hours of sleep per night) _____ Water: (average # cups per day) _____

Do you drink any of the following: (***please list number per day / per week if applicable***)

• Coffee: _____ • Alcohol: _____ • Pop: _____

Please CIRCLE other practitioners you have seen:

CHIROPRACTOR NATUROPATH DIETITIAN MASSAGE THERAPIST PHYSIOTHERAPIST
OCCUPATIONAL THERAPIST SURGEON SPECIALIST(S)_____ OTHER: _____

WOMEN'S HEALTH

Irregular periods: _____ Heavy or painful menstruation: _____Infertility: _____

Number of full-term pregnancies:_____ Number of miscarriages/infant loss: _____

Pelvic floor pain or concerns:_____

Menopausal difficulties:_____

SELECT ALL THAT ARE APPLICABLE:

- ☐ ASTHMA
- ☐ NUMBNESS OR PINS & NEEDLES
- ☐ CONSTIPATION
- ☐ HEARTBURN
- ☐ ARTHRITIS
- ☐ GLAUCOMA OR EYE PROBLEMS
- ☐ SHORTNESS OF BREATH
- ☐ SKIN SENSITIVITIES OR ECZEMA
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ HEART ATTACK OR DISEASE
- ☐ EPILEPSY OR SEIZURES
- ☐ HEARING PROBLEMS
- ☐ HEADACHES OR MIGRAINES
- ☐ EDEMA OR SWELLING
- ☐ AUTOIMMUNE DISEASE
- ☐ PALPITATIONS
- ☐ DEPRESSION OR ANXIETY
- ☐ SINUS ISSUES
- ☐ HEAVINESS
- ☐ VERTIGO OR IMBALANCE
- ☐ NAUSEA
- ☐ HIGH BLOOD PRESSURE
- ☐ ANEMIA
- ☐ EAR/NOSE/THROAT ISSUES
- ☐ FATIGUE OR WEAKNESS
- ☐ APPREHENSION IN LIFTING ARM OR LEG
- ☐ URINARY ISSUES
- ☐ STROKE
- ☐ BLEEDING DISORDER
- ☐ FREQUENT SICKNESS
- ☐ MENSTRUAL PROBLEMS
- ☐ PELVIC FLOOR PAIN
- ☐ VARICOSE VEINS
- ☐ CANCER
- ☐ DIABETES
- ☐ RECURRENT COUGH (DRY/WET)

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WRITTEN CONSENT AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

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

The security, confidentiality, and privacy of the information collected from you is guaranteed.

Patient Access

You are entitled to view the information collected by the therapist regarding yourself. You may obtain a copy of your records. There is a 25-dollar 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 Print Name Signature

WAIVER

I understand that the osteopathic assessment and treatment I am receiving will allow the therapist to treat my body osteopathically, ideally resulting in improved function and pain reduction. I understand that osteopathic manual therapy is tailored to help my body achieve health and wellness using palpation. I have been instructed by the Osteopathic Manual Therapist that the treatment I am about to receive may include myofascial release, cranial-sacral techniques, articular corrections, and organ mobilizations. If I experience any pain or discomfort during the session I am encouraged to communicate this to the therapist. I have been informed and understand that in the days following the session, symptoms may appear to worsen or change before improving. I have been informed that manual osteopathic care is not a substitute for a medical examination or diagnosis, and I should see a healthcare provider for those services.

Date Print Name Signature

Parent or Guardian consent in the assessment and treatment of a child under 18 years of age:

I, _____ (the parent/guardian) o**f**_____ , give written consent and permission to Josh Schellenberg (RMT., D.O.M.P., D.Sc.O.) to assess and treat my child.

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CANCELLATION POLICY

24 HRS NOTICE OF CANCELLATION IS REQUIRED

If the patient does not inform the therapist of the cancellation of a scheduled appointment before the 24-hour period or does not show up for the appointment, **a cancellation fee of 132.30 dollars will be charged**.

An alternative would be to send a friend or family member to attend your session. Please provide the name of the person attending by phone or email.

I have read and understand the above information:

Date Print Name Signature