Holistic Healing Arts

Sean Hauk, DOMP
Diploma in Osteopathic Manual Practice
Reg #18-127

NAME:_____ DATE:_____

ADDRESS:_____

PHONE #:_____ ALTERNATE PHONE #:_____

EMAIL:_____ DATE OF BIRTH:_____

OCCUPATION_____

HAVE YOU EVER RECEIVED OSTEOPATHIC CARE BEFORE? YES NO

HOW WERE YOU REFERRED TO OUR CLINIC? _____

MAIN COMPLAINT/REASON FOR VISIT _____

WHAT TYPE OF PAIN? Radiating_____ Dull/achy_____Sharp _____Acute_____

PAIN SCALE 1 2 3 4 5 6 7 8 9 10

Please look at the following list and check off anything that would be relevant to you.

- ☐ Abdominal Pain
- ☐ Allergies (Oils, Nuts, Fragrances)
- ☐ Arthritis
- ☐ Auto-immune Condition
- ☐ Back Pain: ☐ Upper ☐ Mid ☐ Lower
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cardiac/Circulatory Condition
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Pain: _____
- ☐ Constipation/Diarrhea
- ☐ Contact Lenses
- ☐ Decreased Range of Motion
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Headache
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Injury: _____
- ☐ Insomnia
- ☐ Muscle Strain/Sprain
- ☐ Numbness: _____
- ☐ Scoliosis
- ☐ Seizures
- ☐ Surgery: _____
- ☐ Skin Condition: _____
- ☐ TMJ
- ☐ Varicose Veins
- ☐ Whiplash
- ☐ Other: _____

Please indicate any painful Areas with an "x"

Note any other issues

_____
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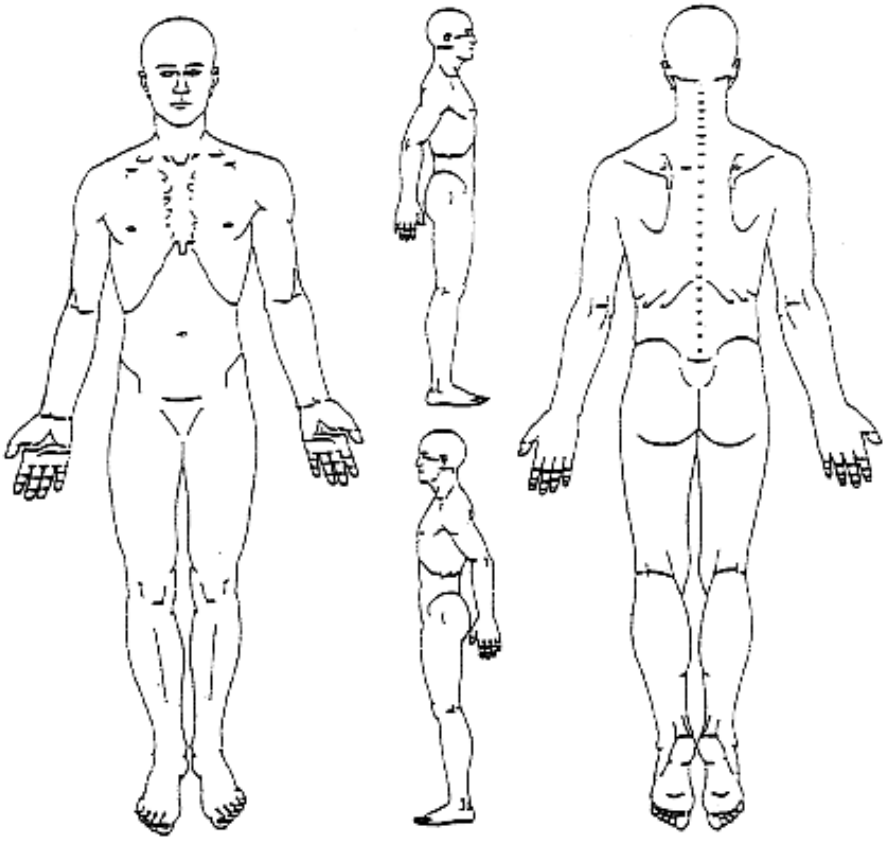

Injuries Including any Motor Vehicle Accidents - Type and Date

_____

Do you have any Internal Pins/Wires/Dental work/Artificial Joints/Special equipment?

_____

Are you receiving any other health care ie, Chiro, Massage, Physio, and for what?

_____

Anything else you need me to know

_____

I deem all of the above information to be true and comprehensive. I understand that my accurate health history helps the practitioner to treat me in the best and safest manner possible. Omission of any pertinent information on my part may result in a negative reaction or outcome of treatment which my practitioner is not responsible for.

PATIENT NAME:_____ **DATE:**_____

SIGNATURE:_____