Mackie Osteopathic Patient Registration

First Name: ______________________ Last Name: ____________________________ Pref. Gender: M F O

Address: ____________________________________ City: ________________ Postal Code: _______________

Contact Phone #: (_____) ____________ Date of Birth: ______________ Health Card #: ____________________

Email: _______________________________________ I do NOT wish to receive emails from Mackie Physio ☐

I wish to receive appointment reminders via: ☐ Email ☐ Text ☐ Both Occupation: _______________________

Family Doctor: _______________________ Surgeon: ______________________ Referred by: ___________________

How did you hear about us? Family___ Friend___ Doctor___Google____Facebook___Instagram___Other_________

Fee For Service/Group Insurance Plan

This clinic is a fee-for-service clinic. The cost of appointments are as follows:

- ***$140 +tax Initial Assessment 9****0 minute*
- ***$110 + tax Reassessment*** *60 minutes*
- ***$80 + tax Follow up 60*** *minutes*

I, the patient, will pay Mackie Physiotherapy for my treatment directly, and, if applicable, will submit the receipt to my group insurance plan for coverage of the treatment expense. Please indicate your understanding of this, and of the cancellation/missed appointment policy, by signing below.

Signature: _________________________________ Date: ________________________

Cancellation/Missed Appointments

Our waiting list is growing significantly, and the cancellations and missed appointments of present patients are affecting their own rehab progress, as well as affecting the many other new patients waiting to attend the clinic. As a result, Mackie Physiotherapy reserves the right to charge a fee for missed appointments, or for appointments that are cancelled with less than 12 hours notice. These fees are to be paid by the patient, not by an insuring party. The fees are as follows:

- Cancellation fee for cancellations occurring with less than 12 hours notice - $10
- **Missed appointment fee – will be the full cost of the appointment**

Please be respectful of the clinicians, the clinic, and your rehab process and make every effort to attend your scheduled appointments. Please also be aware that, as the clinic is very busy, it is difficult to reschedule appointments. Also, for your awareness, if there is a missed appointment or cancellation with less than 24 hours notice, massage therapists on commission-based earnings receive no income.

Signature of Understanding: _________________________________

Consent for Examination and Treatment

I understand that the Osteopathic Therapist is providing osteopathic therapy services within their scope of practice as defined by the Osteopathic Therapist Association of Saskatchewan, Inc.

I hereby consent to my Therapist to treat me with osteopathic therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my Therapist.

I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Therapist, and disclosed to the Therapist all of those medical conditions affecting me. It is my responsibility to keep the Osteopathic Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

____________________________	____________________________	____________________________
Patient Name	Patient/Guardian Signature	Date Signed

Patient Health History

Have you had a Manual Osteopathic Treatment before? ☐ Yes ☐ No
If yes, for what? ____

Are you currently being treated by a Chiropractor, Physical Therapist or Massage Therapist? ☐ Yes ☐ No

Any injuries within the past 72 hours? ☐ Yes ☐ No
If yes, explain: __________________________________

Past surgeries: __________________________ Date: ____________________
__________________________ Date: ____________________

Medications: ____

Allergies (including food allergies): ____

Please indicate **Current** conditions with a **C** and **Previous** conditions with a **P**:

Respiratory:
Chronic cough ____
Shortness of breath ____
Bronchitis/Asthmas ____
Sinus Infections ____
Emphysema ____
Smoke/Vape ____

Cardiovascular:
Cold hands/feet: ____
High/Low blood pressure: ____
CCHF or heart attack: ____
Phlebitis, Deep vein thrombosis: ____
Stroke: ____
Pacemaker or other devices: ____
Swelling in hands or feet: ____

Head and Neck:
Tension/migraine headaches: ____
Tinnitus (ringing in ears):___
Tooth/jaw/ear pain: ____
Vision problems/loss: ____
Hearing loss: ____
Dizziness/lightheaded: ____

Skin:
Bruise easily: ____
Sensitivities/allergies: ____

Digestive:
Constipation, Crohn's, Colitis, IBS: ____
Nausea: ____
Ulcers/blood in stool: ____
Liver/Kidney problems: ____

Soft Tissue and Other:
Soft tissue/Joint/Nerve: ____
Fibromyalgia, Arthritis, RA, OA: ____
Herniated disc(s): ___ Level Loss of sensation ___
Osteoporosis: ____
Diabetes, onset/type: ____
Fracture: ____ Where: _________________
Thoracic Outlet Syndrome: ____
Insomnia: ____
Head trauma/concussion: ____
Depression/Anxiety: ____
Whiplash/car accident: ____
Multiple Sclerosis: __
Neck pain/stiffness/injury/numbness: ____
Cancer (onset/type): ____
Shoulder pain/stiffness/injury: ____
Arm pain/weakness/tingling: ____
Back pain/stiffness/injury: ____
Leg pain/weakness/injury: __
Knee or foot pain/injury: ____
Tendonitis/Tenosynovitis: ____

Women ONLY:
Pregnant: __
Painful Menstruation: __
Hysterectomy: __
C Section: __
IUD: __

Please list any other relevant conditions that were not listed:
____
____

Additional Questions:

Do you get a good night's sleep? ___ yes ___ no

Do you eat a well balanced diet? ___ yes ___ no

Do you have low energy? ___ yes ___ no

I feel good about life. ___ yes ___ no

Current Condition: ____________________

Please describe your current pain: _________________

How long have you had this pain: _________________

How did it start: ______________

What aggravates it: __________________________

What relieves it: _____________________________

Signature: __________________ Date: ___________________________