HEATHER LANG
OSTEOPATH

2 FALFIELD STEADINGS, PEAT INN, KY15 5LJ

Title	Date of birth
Surname	GP
First name(s)	GP Address
Address	
Post code	Occupation
Home telephone	Hobbies
Moble telephone	Source of introduction
Work telephone	Email address

Do you or have you experience any of the following (please give details):

High/Low Blood Pressure	Y / N	Asthma/Breathing difficulties	Y / N
Heart Attach/Chest Pain	Y / N	Arthritis	Y / N
Varicose Veins	Y / N	Diabetes	Y / N
Dizziness/Fainting	Y / N	Stroke	Y / N
Allergies/Food	Y / N	Cancer	Y / N
Headaches/Migraine	Y / N	Pregnant	Y / N
Whiplash	Y / N	Epilepsy	Y / N
Osteoporosis/Osteopenia	Y / N	Other - please give details	Y / N

Details:_____

_____

_____

Please list any medication you are currently taking:

_____

_____

_____

Have you been hospitalised through accident or illness? Y / N

Details:_____

_____

Have you been hospitalised through routine operations including childbirth?:

Details:_____

_____

Have you ever fractures bones or torn ligaments?

Details

_____

_____

I request and consent to the performance of osteopathic manipulation and other osteopathic procedures. I have disclosed all relevant health information and do not expect the osteopath to anticipate every potential risk and complication associated with the proposed treatment or procedure.

By signing this form I agree to pay for treatment received.

Name (print)_____

Signature:_____

Date:_____