**Fulcrum Manual Therapy**

Josh Schellenberg, Osteopathic Manual Therapist

RMT., D.O.M.P., D.Sc.O.

153 RockRidge Dr #103

(431)-996-3929

**Patient History**

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 todays 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, MRI, CT scan

List any other medical procedures you’ve received and their findings:

- -

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

* -
* -

**Lifestyle Information**

How many cups of water do you drink a day: \_\_\_\_\_\_\_\_\_Average hrs of sleep per night \_\_\_\_\_\_\_

Do you drink coffee, alcohol, or pop? # Per day\_\_\_\_ per week \_\_\_\_

Please circle other practitioners you have seen: Chiropractor, Naturopath, Dietitian, Massage Therapist, Physiotherapist, Occupational therapist, Surgeon, Specialist(s) or other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women’s Health**

Irregular periods: Y/N Heavy or painful menstruation: Y/N Infertility: Y/N

Number of full-term pregnancies: \_\_\_\_ Number of miscarriages / infant loss: \_\_\_

Pelvic floor pain or concerns: Y/N Menopausal difficulties: Y/N

**Select all that are applicable:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ Asthma | □ Numbness or pins & needles | □ Constipation | □ Heart burn | □ 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) |

**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 Name Signature

**Waver**

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 through the use of 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 health care provider for those services.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the parent/guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give written consent and permission to Josh Schellenberg (RMT., D.O.M.P., D.Sc.O.) to assess and treat my child.

**Cancellation Policy**

**24 HRS NOTICE OF CANCELLATION IS REQUIRED**

If the patient does not inform the therapist of cancellation of the scheduled appointment before the 24hr period, or does not show for the appointment, a cancellation fee of the 120 dollars will be charged.

An alternative can be to send a friend or family member to attend your session.

I have read and understand the above information;

Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_