



**ELYSIS**

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103-410 Conestogo Rd.,  
Waterloo ON N2L 4E2

**LYNDA KEAST, DO(MP)**

**Osteopathic Manual Practitioner**



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2238 Caroline Street  
Burlington, ON L7R 1M6

**Patient Information** (please print clearly) \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (B) \_\_\_\_\_ (M) \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Where did you find our number? \_\_\_\_\_

If online, what site referred you? \_\_\_\_\_

**Health History**

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Current Medications (conditions they treat): \_\_\_\_\_

Surgeries (Please list and date): \_\_\_\_\_

Please list the presence and location of any internal pins, wires, artificial joints of special equipment: \_\_\_\_\_

Chiropractor: \_\_\_\_\_ Phone: \_\_\_\_\_

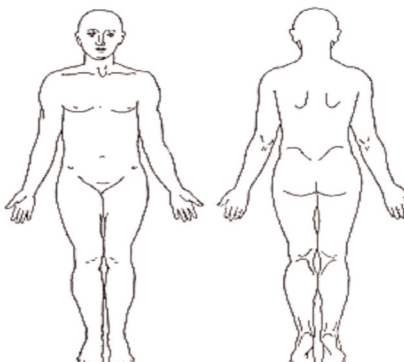
List other current therapies (ie: physiotherapy): \_\_\_\_\_

Motor Vehicle Accident?  Yes  No Date: \_\_\_\_\_

Other Accident(s)?: \_\_\_\_\_

Date(s): \_\_\_\_\_

**Indicate Areas of Pain or Discomfort**



Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***please turn over...***

**Please Check All Applicable Boxes**

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart disease
- Myocardial infarction
- Phlebitis
- Cardio-vascular accident
- Stroke
- Pacemaker
- Varicose veins
- Blood clots
- Osteoarthritis
- Lymphedema
- Other

**Infectious Diseases**

- Hepatitis
- Tuberculosis
- HIV
- Other \_\_\_\_\_

**Musculo-skeletal**

- Bone or joint disease
- Tendonitis
- Bursitis
- Fractures
- Osteoarthritis
- Rheumatoid arthritis
- Sprains/strains
- Swelling
- Stiffness
- Spasms/cramps
- Pain (check area)  
    \_\_Jaw \_\_Neck \_\_Shoulder  
    \_\_Elbow \_\_Wrist \_\_Hip  
    \_\_Knee \_\_Ankle \_\_Back

**Digestive**

- Constipation
- Gas/bloating
- Nausea/vomiting
- Irritable bowel syndrome
- Liver/gall bladder
- Kidney/bladder
- Other \_\_\_\_\_

**Skin**

- Allergies (anaphylactic)
- Rashes
- Athletes foot
- Warts
- Cold sores
- Eczema/psoriasis
- Other (contagious)

**Respiratory**

- Chronic cough
- Bronchitis
- Shortness of breath
- Asthma
- Emphysema
- Smoking
- Other

**Reproductive**

- Pregnancy (trimester \_\_\_\_\_)
- PMS
- Other \_\_\_\_\_

**Nervous System**

- Herpes/shingles
- Numbness/tingling
- Chronic pain
- Fatigue
- Sleep disorder
- Loss of sensation
- Other

**Other**

- Drug/alcohol addiction
- Nicotine/caffeine addiction
- Diabetes
- Vision/Hearing loss
- Cancer
- Epilepsy
- Headaches/migraines

How often: \_\_\_\_\_

- Allergies  
    \_\_Food \_\_Drug  
    \_\_Environmental

**Client Consent Statement**

In keeping with the Health Care Consent Act (1996), it is my choice to receive therapy. I understand that an assessment by a therapist is required to determine the best course of treatment. I am aware that all information provided is private and confidential and will not be released without my written consent. I agree to communicate with my therapist at any time if I have any questions, if I feel uncomfortable, or I feel that my well being is being compromised. I will consent to the therapist working only on those areas of my body that I am comfortable with. I am aware that I may remove only the clothing with which I am comfortable and may terminate the treatment at any time at my discretion. I understand and am aware of the posted fees and cancellation policy. I am also aware of the possible side effects from a treatment such as temporary muscular discomfort (24-48hrs post treatment) and possible dizziness. I understand the therapist will recommend remedial exercises and home care. I am aware that the clinic is not responsible for any lost, stolen or damaged articles.

**Cancellation Policy**

We require 24 hours notice if you are unable to make your scheduled appointment. After an one initial warning all subsequent missed appointments will then be billed at the regular fee.

Signature (18 years of age or older): \_\_\_\_\_ Date: \_\_\_\_\_

Parental/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_