Back in Balance
A centre for wellbeing

Osteopathy Intake

Name:_____ ❒ Female ❒ Male ❒Other Birth Date:_____

Address:_____ Phone:_____ Email:_____

Occupation:_____

Reason for appointment: _____

When did this begin? : _____

Have you ever had similar problems? ❒ Yes ❒ No What? :_____

How did this occur? :_____

Is this condition related to: **Work** ❒ Yes ❒ No
Has your employer been notified ❒ Yes ❒ No
Motor Vehicle accident? ❒ Yes ❒ No Date of Injury:_____

What have you done for this condition?: _____

Have you had Xrays, MRI or other tests for these conditions? ❒ Yes ❒ No

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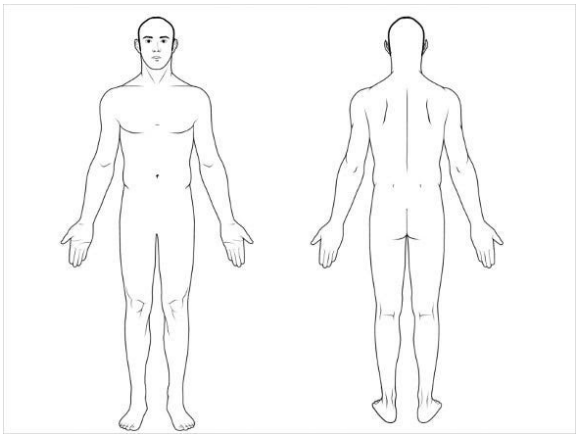
Numbness, loss of sensation, strength or weakness in face, fingers, hands, arms, legs or other part of the body? ❒ Yes ❒ No

Using the symbols below, mark on body diagram:

X= **Pain**
O= **Numbness**
Z= **Tingling**
/= **Other** _____



Using the line scale, indicate the **severity of the pain** your are experiencing now:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Extreme Pain**

Comments:_____