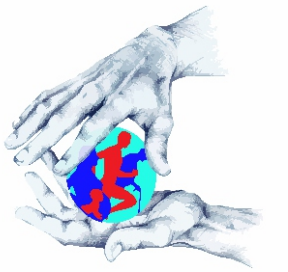


Anne-Laure Lesoin

Osteopathic Manual Therapist
D.O - France

Confidential Patient Case History Form

Personal Information: Today's Date: _____

First name: _____ Last name: _____

Date of Birth: _____ Occupation: _____

Address: _____

Mobile phone number: _____ Home phone number: _____

E-mail address: _____

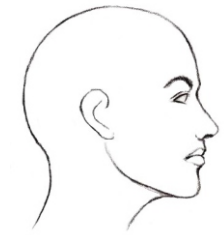
Emergency contact information:

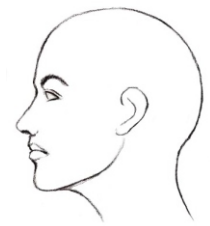
Name: _____ Relationship:_____ Phone: _____

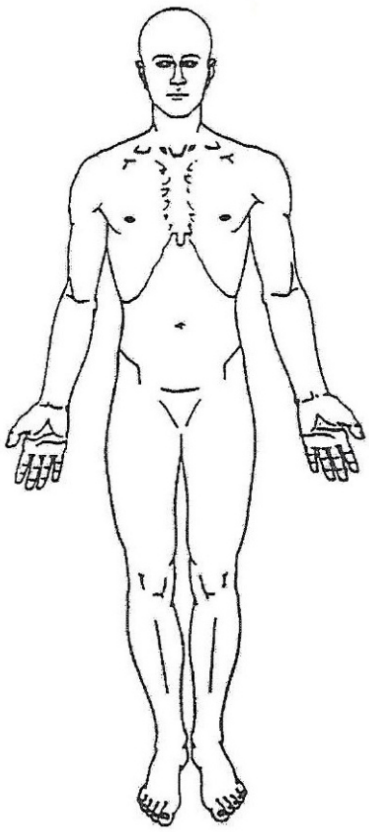
Personal Health Information:
Are you presently taking any medication? ☐ No ☐ Yes If yes, please describe:

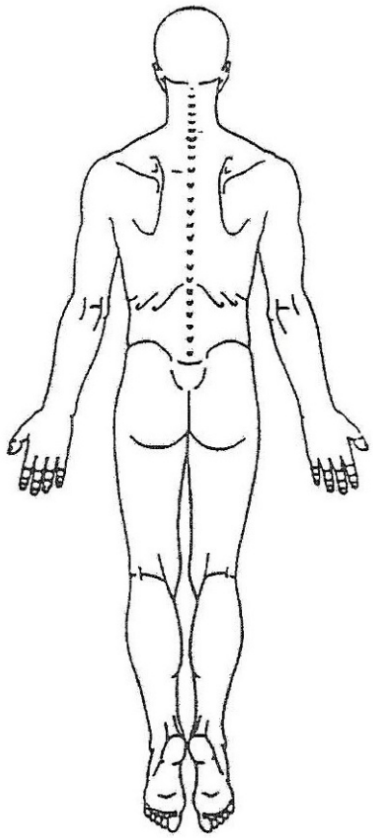
_____

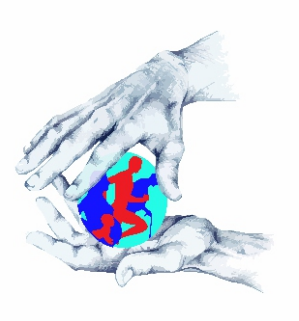
Indicate area(s) of concern below:











Anne-Laure Lesoin

Osteopathic Manual Therapist
D.O - France

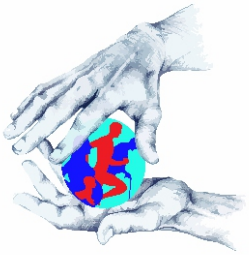
Confidential Patient Case History Form

Consent:
In adherence to the Freedom of Information & Protection of Privacy Act this information is strictly confidential and will be used exclusively to assist in the best treatment possible for the client below. All information becomes the property of Anne-Laure Lesoin Osteopathic Manual Therapist (D.O-France) and as legally required, may be retained for a minimum period of seven years.I certify that the information provided on this form is true and correct to the best of my knowledge. I understand email confirmation and reminders are provided as a courtesy and I am responsible for my schedule. I hereby agree that it is my responsibility to keep my therapist properly informed of any changes in the state of my health. I understand and agree to these conditions.

Cancellation Policy:
I understand and agree that I must provide a minimum of 24 hour advance notice of all cancellations. ***A full appointment fee will be charged for cancellations without sufficient notice.***

Signature: _____ Today's date:_____

Guardian's signature: _____ (if patient is 17 yrs. old & younger)



Anne-Laure Lesoin

Osteopathic Manual Therapist
D.O - France

Confidential Patient Case History Form

In Osteopathy, we consider your body's story since the beginning. Please describe below your history since childhood including any relevant family history.

Physical trauma
eg: car accident / whiplash / sporting accidents / broken bones / sprains / loss of consciousness

Emotional trauma
eg: loss of loved one / anxiety and depression / birth trauma

Screening & Surgery
eg: x-ray / CT scan / MRI / ultrasound / colonoscopy / appendectomy / tonsils removed / c-section / Lasik eye surgery / abortion / local or general anaesthetic

Head & Mouth
eg: migraines / headaches / dental work (filling, root canal, crown, extraction, mouth guard, braces, retainer Invisalign, clenching, grinding) / TMJ / eyesight (nearsightedness, farsightedness, astigmatism)
ears & hearing (infections, aches, tubes, ringing) / dizziness

Throat & Lungs
eg: bronchitis / pneumonia / asthma / strep throat

Cardiovascular
eg: high blood pressure / stroke / cholesterol / diabetes / heart problem / phlebitis / blood clots

Digestive & Renal
eg: bloating / acid reflux / hiatal hernia / food intolerances & allergies / constipation / diarrhea / hemorrhoids / diverticulitis / IBS / blood in stool / gas / Crohn's disease / colitis / ulcers / urinary infection / bladder infection / kidney infection / kidney stones

Reproductive
eg: ♀ menstrual cramps / endometriosis / fibroids / ovarian cysts / pregnancy / miscarriage / PMS menopause ♂ prostate

Major Illness Diagnosis & Treatment
eg: cancer / chemotherapy / radiation

General
eg: sleep / skin conditions / sport & activities