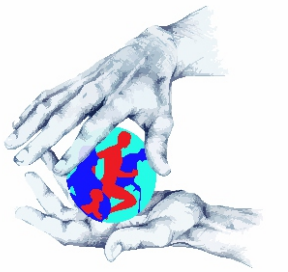


Anne-Laure Lesoin

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: _____

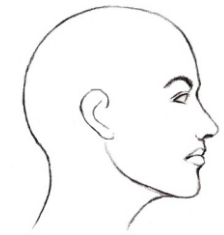
Emergency contact information:

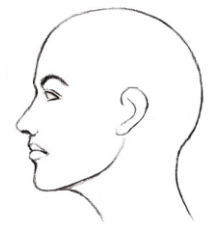
Name: _____ Relationship:_____ Phone: _____

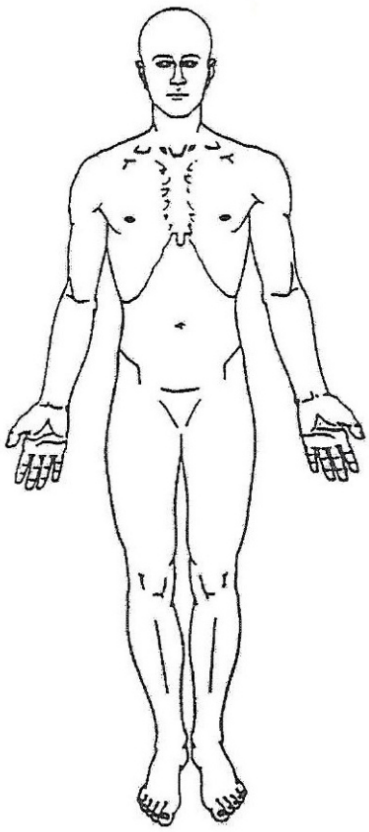
Personal Health Information:
Are you presently taking any medication? ☐ No ☐ Yes If yes, please describe:

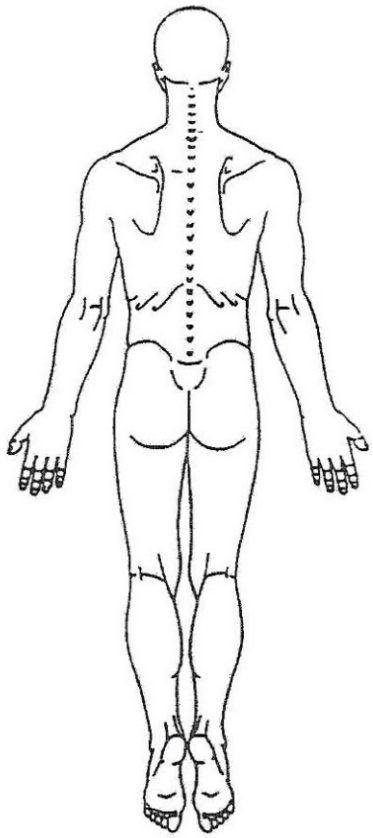
_____

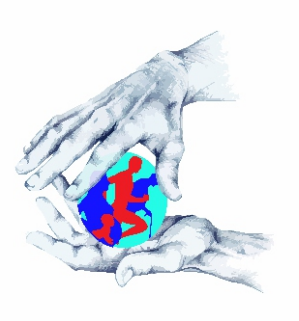
Indicate area(s) of concern below:











Anne-Laure Lesoin

Osteopathic Manual Therapist
D.O - France

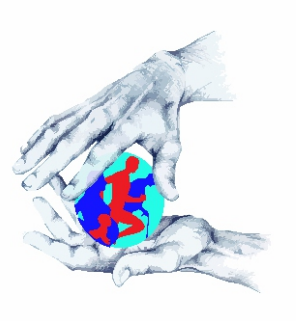
Confidential Patient Case History Form

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
Child - up to/including 4 yrs. old

Mother's Name _____ Father's Name _____

Conception:
Did you have difficulty conceiving? _____ How many pregnancies? _____ How many children?_____

Any other details about conception? _____

_____

Pregnancy:
Due Date _____ Term (weeks) _____

Did you experience any physical or emotional trauma during your pregnancy? _____

Any other details about your pregnancy? _____

_____

Delivery:
Hospital or Home Birth _____ Hours in Labour _____ Presentation: _____

☐ Vaginal Delivery C-section ☐ Planned or ☐ Emergency ☐ General Anaesthesia

☐ I.V. ☐ Epidural ☐ Spinal anaesthesia ☐ Pressure on stomach ☐ Induction/oxytocin

☐ Demerol ☐ Forceps ☐ Suction ☐ Cord around neck ☐ Resuscitation

☐ Problems delivering placenta

Any other details about delivery? _____

_____

Postpartum:
☐ Jaundice ☐ N.I.C.U. _____ ☐ Colitis Bowel Movements _____

☐ Torticolis ☐ Heart Rate _____ Apgar score _____ ☐ tongue tied ☐ Vaccines _____

☐ Breastfeeding, If not why? _____

Any other details postpartum? _____

_____