

FAX: 844-526-0693 PH: 807-700-1600

On January 1, 2004 the Personal Information Protection and Electronic Documents Act (the Act) came into effect with a mandate to balance the privacy rights of the individual and the needs of commercial organizations to collect information for business purposes.

Drew Osteopathy remains committed to you, your health, and respects your right to confidentiality. The privacy policy of Drew Osteopathy is founded on the following principles:

# **Accountability**

Drew Osteopathy (DO) is responsible for maintaining and protecting all information collected by the clinic. Tara Drew is the Privacy Officer for DO, and will address any of your inquiries. Please contact Tara at: Info@Drewosteopathy.ca, 807-700-1600 in Sioux Lookout.

#### Limited and Accurate Collection of Information

DO limits the collection of personal information to that which is necessary for the provision of excellent health care. This information is accurately maintained in its most current form in order to fulfill the purposes for which it was collected.

#### Consent

A decision to receive care at DO implies consent for the sharing of information internally, for purposes related to your health care only. Written consent is required from you in order to share your health care information externally. You may withdraw this consent in writing at any time.

#### **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.

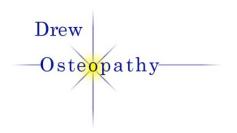
## **Information Storage**

Appropriate security measures are utilized to secure the privacy of all information collected in the delivery of your health care services.

## **Patient Access**

You are entitled to view the information collected by DO regarding yourself. You may obtain a copy of your records. There is a fee for this service.

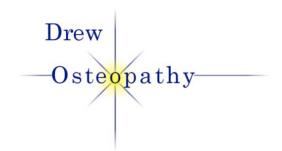
•		se, maintenance and disclosur	3 1	
information	as indicated above, unle	ess and until I advise otherwise	se in writing.	
Date	Name	Signature	Witness	



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# RELEASE OF INFORMATION, INFORMATION COLLECTION, ASSESSMENT, AND TREATMENT CONSENT FORM Drew Osteopathy

I,	, authorize Drev	v Osteopathy
I,Name of Guardian/Patient		
[ ] to collect and store		's personal information
(initials) Patien	nt's name	's personal information
to be used solely treatment reco	ord purposes.	
[ ] to assess and treat		having been informed of
		d. By signing this form you acknowledge that you consent
		or questions about treatment answered to your satisfaction.
		ice his/her hands on your body. Body and hand contact
		domen, tailbone, pelvic floor and pubic bones. Intraoral
palpation may also be required.		
		ear loose fitting clothing. You need only disrobe to the
		comfortable with a given technique, please indicate that to
		as to the risks and benefits of the technique. An
		occurrences will be provided. The technique will be
modified or discontinued based		
	1 3	
[ ] to provide information, op (initials)	oinions, notes and	reports to
Name(s) of practitioners/people and ad		
which they may request regardi	ing the condition a	and treatment of
	, and any o	documents related to this condition.
(condition/ailment/diagnosis)/patient		
(initials)		garding my condition for which I am
come none continuent		<del></del> ·
I have the right to withdraw con	nsent at any time	either verbally or in written format.
signature	date	
Parent/Guardian (please print)		
raicin/Quardian (picase print)		
Witness signature	date	Witness (please print)



M	Medical History Questionnaire	
Na	Name:	Date of Birth:
Ac	Address:	
Ph	Phone: (h)(w)	Email:
ma tak	maximize the amount of treatment time available	aformation regarding your history as possible so as to ilable on your appointment day. This questionnaire from birth to present. When possible, please provide al paper as necessary.
1.	1. Medications: Please list all medications	, vitamins, supplements
2.	<ol> <li>Investigations: X-rays, CTScans, MRIs findings.</li> </ol>	, EMGs, U/S, within the last 5 years or significant
3.	3. Chief Complaint: reason for appointme	ent
4.	4. Secondary complaints: what else is both	hering you

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Name:

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<u> </u>	When did it start?		
	Is it getting better or worse or not changing?  Is the pain local or does it go into a leg or arm – try to describe as exact as you can.		
	What kind of pain is it — sharp/dull/burning/achey/stabbing/shooting? What makes it worse—movement/rest/specific activity? What makes it better?		
6.	What treatment have you had so far? Is it making a change?		
7.	Personal birth history: Were there any complications, long/fast labour, forceps/suction/c-section?		
8.	Surgeries: any kind at any time: tonsils, gall bladder, etc.		
9.	Cancers:		
10	Medical problems: diabetes/high blood pressure/cardiac problems/neurological		
11	. Fractures: At any time		
12	Motor vehicle Accidents		

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Name:

13.	Falls – on ice, down stairs, out of trees
14.	Head Injuries – loss of consciousness, concussions, stitches
15.	Musculoskeletal injuries: sprains, strains, dislocations, back/neck pain
16.	Headaches: history of migraines/severe headaches/tension headaches/TMJ
17.	Eyes: when last checked/any changes/eye diseases
18.	Ear/Nose/Throat: any history of infections as a child, ear tubes, sinusitis, strep throat
19.	Dental: braces/extractions/fillings/plates/bridges/root canals/TMJ
20.	TMJ: clicking/locking/unable to open/unable to close/grinding/ pain with chewing/ear pain/headaches

21.	Respiratory: pneumonia/bronchitis/as	sthma/smoker	_
22.	Cardiac: any heart problems		_
23.	Digestion: mono/hepatitis/jaundice/birritation after eating	ploating/indigestion/heart burn/constipation/diarrhea/	
24.	Urogenital: bladder/kidney infections menstrual problems—cramping/ble pregnancies/deliveries/C-sections/e prostate—PSA results/urinary freq	epidurals	_ _ _
25.	Sleep: any difficulties getting to sleep wake rested	o, staying asleep, any specific time wake in night,	
26.	Stressors:		_
Any	ything else that you think is related or i	mportant:	
Ple	ase bring to appointment or email to	info@drewosteopathy.ca	
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Name: \_\_\_\_