YOUR HEALTH

Wellness Centre
200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Massage Therapy New Patient Form

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B)_____ (M)_____

Email: _____ (to receive appointment reminders)

☐ Add me to the email newsletter (Our newsletter covers events at the clinic and highlights informative articles written by our therapists. You can unsubscribe from the newsletter at any time.)

Occupation: _____ How did you find out about us? _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

Fee Schedule

90 minute massage therapy $140.00	60 minute massage therapy $100.00
30 minute massage therapy $60.00	45 minute massage therapy $75.00

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist. In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning, appointments cancelled with less than 24 hours notice will be charged in full, unless the appointment is rescheduled within 48 hours.

Custom-made orthotics will not be ordered for a patient until the patient has paid at least 50% of the item cost. We do realize that custom orthotics are an expensive part of treatment and we do make every attempt to control these costs. Our staff is available to assist patients with insurance benefit verification for such items.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with YOUR HEALTH to be a pleasant one and we hope this information will help to make it so.

I have read the Your Health Wellness Centre financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. I HEREBY AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT YOUR HEALTH WELLNESS CENTRE.

Patient Signature: _____ Date: _____

Consent for Treatment for Massage Therapy

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I am also aware of the possible side effects from a massage treatment such as temporary muscular discomfort (24-48hrs post treatment), bruising and possible dizziness.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures(s). I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: _____

(parent/guardian if under 18)

Patient Name: _____ Date: _____

Health History

Medical Doctor: _____Phone:_____

Previous Chiropractic care: (Name) _____ (Phone Number) _____

Current Medications (including vitamins and supplements):

Previous fractures, surgeries, or hospitalizations (Please list and date):

List any medical problems that other doctors have diagnosed: _____

_____

List other current therapies (ie: physiotherapy, massage):_____

Exercise level:
- □ Sedentary (no exercise)
- □ Mild exercise (e.g. Climb stairs, walk 3 blocks, golf)
- □ Occasional exercise (e.g. work or recreation less than 4x/week for 30 min)
- □ Regular vigorous exercise (e.g. work or recreation 4x/week or more for 30 min)

For Women Only:

Are you pregnant or breast-feeding?	□ Yes	□ No
Have you had a D&C, hysterectomy, or Cesaerean section?	□ Yes	□ No
Any urinary tract, bladder, or kidney infections in the past year?	□ Yes	□ No

Other Problems:

Respiratory
□ Chronic cough
□ Shortness of breath
□ Bronchitis
□ Asthma
□ Emphysema
Is there a family history of the above?
_____
Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Chronic congestive heart failure
□ Heart attack
□ Heart disease
□ Phlebitis
□ Stroke/CVA
□ Pacemaker or similar device
Is there a family history of the above?
_____
Skin
□ Skin irritations
□ Skin conditions
Type: _____
Location: _____

Other Conditions
□ Loss of sensation
□ Diabetes
Type: _____
Onset: _____
□ Allergies
Type:
□ Epilepsy
□ Cancer
Type: _____
Location: _____
□ *Arthritis*
Type: _____
Location: _____
If there a family history of arthritis? _____

Head/Neck
□ *Vision problems*
□ *Vision loss*
□ *Ear problems*
□ *Hearing loss*
Infections:
□ *Hepatitis*
□ *Skin conditions*
□ *Tuberculosis*
□ *HIV*

Women:
□ *Pregnant*
Due date: _____
Gynaecological conditions if any?
_____
Other areas of pain/discomfort:

Soft Tissue/Joint discomfort:
□ *Neck*
□ *Low back*
□ *Mid back*
□ *Upper back*
□ *Shoulders*
□ *Arms*
□ *Legs*
□ *Knees*
□ *Other:* _____
What is your general health status?
_____
_____

YOUR HEALTH

Wellness Centre

200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Privacy Policy

Privacy of personal information is important to Your Health Centre. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, the College of Massage Therapists of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Massage Therapists Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how our clinic will use my personal information.

I agree that Your Health Centre can collect, use, and disclose my personal information as set out above in the College's privacy code.

_____
(Signature)

_____
(Print name)

_____
(Date)

_____
(Signature of Witness)

YOUR HEALTH

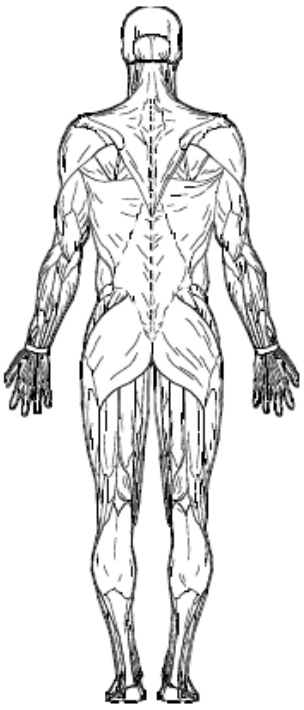
Wellness Centre
200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Initial Assessment

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions