357 king St., midland ON L4R 3M7
t: (705) 526 6900 f: (705) 526 6460

Registered Massage Therapy **Date:** ______________________

Please Read Carefully

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let Health Works Chiropractic & Wellness Centres' Massage Therapist know. Health history will be updated yearly. All information gathered for this treatment is confidential except as required or allowed by law; or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Name:
____

Address:
____

Province: ___________ Postal Code: ____________

City: _______________________________________

Occupation: ____________________________

Home Phone Number: (____)_________________

Birth Date: _____/____/______ Age: ________
MM / DD / YEAR

Cell Phone Number: (____)____________________

Cell Phone Company Name: _________________

Work Phone Number: (____)_________________

Emergency Contact: ________________________

Emergency Phone Number: (___)_____________

Email Address: ____

Referred by: ____

How would you like appointment reminders?

☐ Home Phone ☐ Texting ☐ Email

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Registered Massage Therapy Samatha Dickey and Allyson White

Treatment Notes for: ______________________________ Date: _______________ DOB:_______________

Health History **Please indicate any conditions you are experiencing or have experienced.**

Cardiovascular
- □ high blood pressure
- □ low blood pressure
- □ congestive heart failure
- □ pacemaker / device
- □ heart disease / heart attack
- □ stroke / CVA
- □ other: ___________________________

Respiratory
- □ chronic cough
- □ shortness of breath
- □ bronchitis
- □ emphysema
- □ asthma
- □ other: ___________________________

Infections
- □ hepatitis
- □ skin infection: ___________________
- □ TB
- □ HIV
- □ other: ___________________________

Bone
- □ osteoporosis
- □ osteomalacia
- □ arthritis/family history
- □ other

Other Conditions
- □ epilepsy
- □ diabetes, onset: _________________
- □ loss of sensation, where? ___________________________________
- □ cold hands and / or feet
- □ varicose veins
- □ allergies: ________________________
- □ cancer
- □ other: __________________________
- □ skin irritations or conditions: ___________________________________

Women
- □ pregnant

due: __________________

Head / Neck
- □ vision problems
- □ hearing problems / loss
- □ sinus problems
- □ TMJ (jaw problems)
- □ headaches / migraines
- □ other: ___________________________________

Soft Tissue / Joint Discomfort
(please state nature of concern)
- □ neck: ___________________________
- □ shoulders: _______________________
- □ upper back: ______________________
- □ mid back: ______________________
- □ low back: _______________________
- □ arms: ____________________________
- □ legs: ____________________________
- □ other: ____________________________

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
Do you have any internal pins, wires, artificial joints, or special equipment? ☐ Yes ☐ No
Have you had massage before? ☐ Yes ☐ No

Who may we thank for referring you to this office? ____

Other medical conditions:____

Injury or Surgery:____ Date:____________________

____ Date:____________________

Medications: ____ Taken For: ________________________

Medications: ____ Taken For: ________________________

Doctors Names, addresses and phone numbers:
____
____
____

Please fill in the form as completely as possible. Accuracy is very important.

Registered Massage Therapy Page two.

Client Information Sheet for the Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of providing you with quality massage therapy. This information sheet will provide you with a general outline to ensure that:

- Only necessary information is collected about you.
- Your information is only shared with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols.
- Health Works Chiropractic & Wellness Centres' privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Massage Therapists of Ontario and the Law.
- Your files and their contents are the property of Health Works Chiropractic & Wellness Centre and shall be used by our designated Registered Massage Therapy Practitioner.

I have reviewed the information above that explains how my personal information will be collected, used and disclosed. I understand and/or agree to the following:

- To provide me with massage therapy, some personal information about me (for example: name, address, telephone number and other healthcare providers) will be collected and agree to the terms and conditions as set out above.
- I have the right to discontinue my assessment or massage therapy treatment at any time.
- I have fully disclosed all medical conditions that I am aware of and understand that it will be my responsibility to inform at massage therapist of any changes in my health status.
- I intend this consent to apply to all of my present and future registered massage therapy care, provided through Health Works Chiropractic & Wellness Centre.

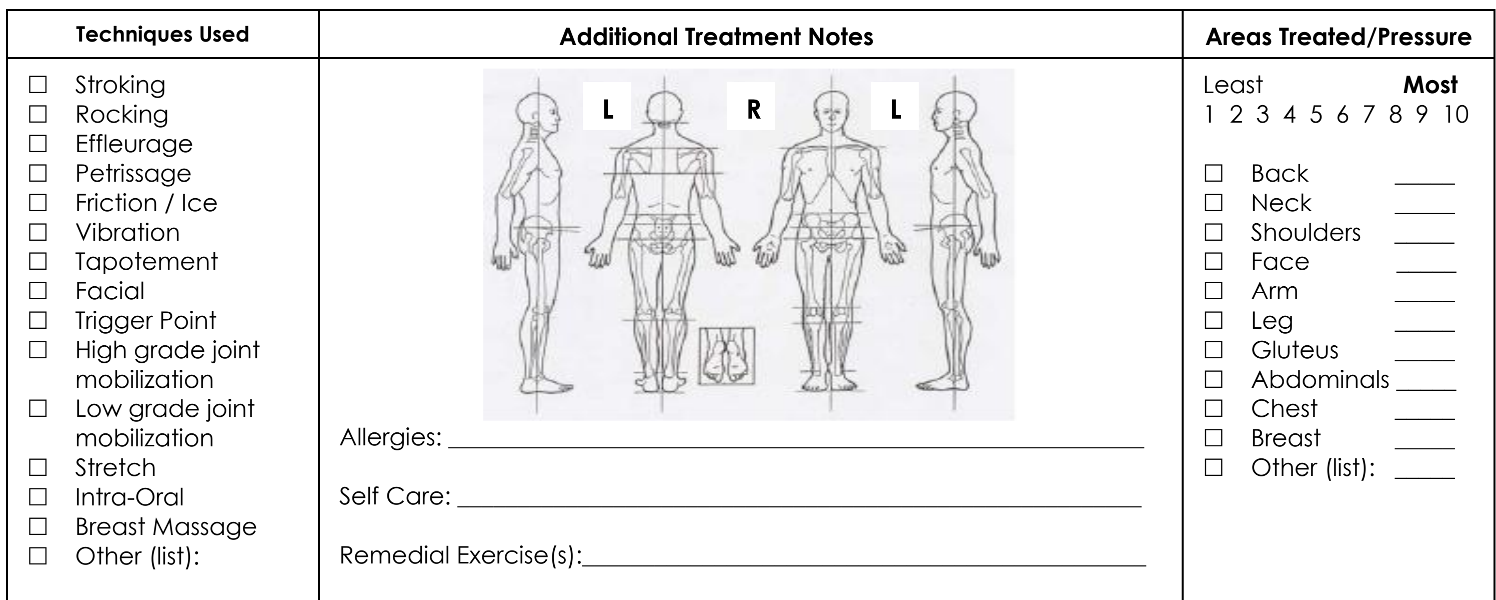
As stated in the "Consent to Treatment" Act, I have the right to consent to all or part of the session, or to withdraw consent at any time and have the right to know specifically what I am consenting to. I have the right to ask questions at any time and to communicate information (such as pain/discomfort levels) throughout the session to ensure my own safety and the effectiveness of the session.

I confirm that the information on this form is complete and true to the best of my knowledge and I understand that it is my responsibility to inform my therapist of any changes in my health status, as they occur.

Date	**Print Name**	**Client Signature**
Date	**Print Name**	**Witness' Signature**

Date: MM / DD / YYYY **Time:** ____________a.m. p.m. **Duration:** __________minutes **Fee $**____________

Informed Consent Received: Treatment Assessment **Therapist:**______________________________



Techniques Used	Additional Treatment Notes	Areas Treated/Pressure
☐ Stroking ☐ Rocking ☐ Effleurage ☐ Petrissage ☐ Friction / Ice ☐ Vibration ☐ Tapotement ☐ Facial ☐ Trigger Point ☐ High grade joint mobilization ☐ Low grade joint mobilization ☐ Stretch ☐ Intra-Oral ☐ Breast Massage ☐ Other (list):	L R L Allergies: ______ Self Care: ______ Remedial Exercise(s):______	Least Most 1 2 3 4 5 6 7 8 9 10 ☐ Back _____ ☐ Neck _____ ☐ Shoulders _____ ☐ Face _____ ☐ Arm _____ ☐ Leg _____ ☐ Gluteus _____ ☐ Abdominals _____ ☐ Chest _____ ☐ Breast _____ ☐ Other (list): _____

Comments:

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OFFICE POLICY REGISTERED MASSAGE THERAPY

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and provide you with the best family health care available. In return you will receive restored health. It is our experience that our practice members who follow these simple guidelines obtain the best results and greatest benefits to their health. We ask that you read the following and initial that you have read them.

Appointment Scheduling / Missed Appointments Initial ___________

We have designed a specific course of action to allow proper care. A personal appointment calendar has been designed for you to save time on each visit. If an appointment must be changed, 24 hours notice is appreciated. All missed appointments should be rescheduled to maintain your care plan. Reception is available 24 hours per day through the telephone message system, calls will be returned as promptly as possible.

Broken Appointments Initial ___________

“No Show” appointments are subject to a full charge for the service booked.
Giving 24 hours notice of cancellation allows that time spot to be booked with another client in need, as there is often a waiting list. We can make a reminder call of your appointments upon your request.

Financial Agreements Initial ___________

Payment is due upon completion of your appointment. A receipt will be issued for submission to your health plan. Payments are made to Reception, and your payment method is Cash, Interact, Visa, or MasterCard. An NSF fee of $45 will be charged for any returned cheques.

Massage Excellence Initial ___________

Our massage practitioners are occasionally out of the office to attend seminars and conferences to further their education to improve your care. We will build your schedule around those times.

Remember Initial ___________

It takes time for your body to heal. If you do not feel satisfied with your body’s responses, please make an appointment to discuss this with your Practitioner, through reception. We want you to get the most from your massage therapy. Any feedback is good feedback.

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Referrals Initial ___________

The best way to say thank you to us is to tell the people in your life about our office. If you know someone who would benefit from Massage Therapy, we would be happy to give you some literature about our office and how Massage Therapy may help with his or her specific symptom. You may also refer them to our website: www.healthworkscentre.com.

We Respect Your Privacy Initial ___________

We respect your privacy and will only collect information that is essential for your care in our office. Being a practice member of Healthworks Chiropractic & Wellness Centre, we will keep you informed of the latest news on health and our Centre. In order to keep you up to date, and celebrate your steps towards health, we need your permission:

Insurance Company: Initial ___________

May we report to your insurance company, if they call, to confirm your appointment dates? ☐ Yes ☐ No This will avoid your payment being denied.

May we contact you via e-mail? **Initial** __________

Please print email here:
____

To contact you by phone & leave messages Initial _______

To thank you for referrals and celebrate wellness Initial ______

To receive newsletters and other informational mailings Initial _______

To receive notice of promotions and special offers Initial _______

I have read and understand the above policies and agree to abide by them.

Signed ____________________________________ Date _____________________________

Witness ___________________________________ Date _____________________________