



Confidential Patient Health Record

Patient information

Date: ____/____/____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home _____ Work _____

Cell: _____ Email: _____

Date of birth (dd/mm/yy) ____/____/____

Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship to contact: _____

Have you received massage therapy before? Yes No

Name of Medical Doctor: _____

Address: _____ May we contact your doctor? Y / N

How did you hear about the clinic? Internet__Ad __Doctor__Other __Friend (name) _____

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u> High blood pressure Low blood pressure Chronic congestive heart failure Heart attack Phlebitis/ varicose veins Stroke/CVA Pacemaker or similar device Heart disease</p> <p><u>Respiratory</u> Chronic cough Shortness of breath Bronchitis Asthma Emphysema</p> <p>Is there a family history of any of the above? Yes / No</p>	<p><u>Infections</u> Hepatitis Skin conditions TB HIV Herpes</p> <p><u>Other conditions</u> Loss of sensation, where? _____ Diabetes, onset: _____ Allergies/hypersensitivity to what? _____ Type of reaction: _____</p> <p>Epilepsy Cancer, where? _____</p> <p>Skin condition, what? _____</p> <p>Arthritis Is there a family history of arthritis? Yes / No</p>	<p><u>Head/Neck</u> History of headaches History of migraines Vision problems Vision loss Ear problems Hearing loss</p> <p><u>Women</u> Pregnant, due: Gynecological conditions, what? _____</p> <p>Overall, how is your general health? _____</p>
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<p>Current Medications:</p> <p>_____</p>	<p>Do you have any other medical conditions? (ie. Digestive conditions, hemophilia, osteoporosis, mental illness)</p>
<p>Condition it treats:</p> <p>_____</p>	<p>Yes/ No What? _____</p>
<p>Are you currently receiving treatment from another health care professional? Yes No If yes, for what?</p> <p>_____</p>	<p>Do you have any internal pins, wires, artificial joints or special equipment? Yes No What? _____</p>
<p>Surgery- date: _____</p>	<p>Where? _____</p>
<p>Nature: _____</p>	<p>What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.</p>
<p>Injury- date: _____</p>	<p>_____</p>
<p>Nature: _____</p>	<p>_____</p>

<p>Date of Initial Health History</p>
<p>Update 1: _____</p>
<p>Update 2: _____</p>
<p>Update 3: _____</p>
<p>Update 4: _____</p>

Personal information collected, used, stored and disclosed by this medical practice is confidential information. 24hrs notice is required to cancel or change appointments otherwise full charges apply.



Privacy Policy

Massage treatments are provided following a routine. The therapist will spend the first few minutes interviewing and assessing you. Together you will discuss the plan for the day's treatment. The hands on treatment will follow; all reasonable efforts are taken to maintain your modesty and privacy.

If you feel uncomfortable **at any time**, the treatment can be stopped or modified at your convenience.

Clients are asked to give 24 hours notice for any appointment cancellations. Should a client arrive late, the appointment will end at the scheduled time.

For any missed appointments the client will be charged for the full fee.

The information gathered at this clinic will not be shared unless:

- Required by law
- To collect payment from a third party
- Client requests us to do so
- To request advice on a client case (identity will not be revealed)

Please note that the clinic will not accept harassment of any nature. This includes suggestive remarks, sexual banter, and unwanted touch without consent. We will not treat anyone under the influence of recreational drugs or alcohol.

I acknowledge that I have read this consent form and I have discussed, or have been offered the opportunity to discuss, with my Registered Massage Therapist the treatment options and recommendations for my treatment, and all of the above in Privacy Policies at Ottawa Chiropractor and Sports Injury Clinic.

I consent to the massage therapy treatment recommended to me by my Registered Massage Therapist.

I intend this consent to apply to all my present and future Massage Therapy treatments.

Date this _____ day of _____, 20_____

Client Signature _____ Witness Signature _____