Merivale Chiropractic Clinic
Merivale Mall
1642 Merivale Rd., Unit 360
Ottawa, ON K2G 4A1

FOR OFFICE USE Date: _____ ID#: _____

Massage Therapy (Patient Introduction)

Personal History

☐Mr., ☐Mrs., ☐Miss, ☐Ms., ☐Dr., ☐Mstr.

First Name: _____ Surname: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Email: _____

☐ Check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

Business Employer: _____ Type of Work: _____

Birthdate: (DD-MM-YYYY) _____-_____-_____ Sex: ☐M ☐F

Height: _____ Weight: _____

Who is Responsible for Your Bill? ☐You ☐Spouse ☐Auto Ins ☐Extended Health Ins

How did you hear about our clinic? _____

Current Health Condition

Major Complaint: _____

General Health Condition ☐Terrible ☐ Poor ☐ Okay ☐ Fine ☐ Good ☐ Great

Previous Treatment for this Condition: _____

When did this condition begin? _____ Other family with same condition? _____

If disabled from work please give dates: _____

Are you currently involved with another Health Care Practitioner? _____

Health History

Medical Doctor* Name _____ Phone # _____ ☐ N/A

***(Information required)** Address _____

Medication You Now Take: ☐Nerve Pills ☐Insulin ☐Blood Pressure ☐Pain Killers ☐Muscle Relaxants

☐Other _____

Major Surgery/Operations: ☐Appendix _____ ☐Tonsils _____ ☐Hernia _____

(Please give date) ☐Heart _____ ☐Back _____ ☐ Neck _____

☐Leg _____ ☐other _____

Major Accidents or Falls: _____

Hospitalization (other than above): _____

Family History of Arthritis: ☐Yes ☐No

Have you had Massage Therapy before? ☐Yes ☐No

Have you been treated for any health conditions in the last year? ☐Yes ☐No

If yes, explain: _____

Health History (cont'd)

MUSCLE OR JOINT PAIN

☐ Neck
☐ Low back
☐ Mid back
☐ Upper back
☐ Shoulders
☐ Leg: left/right
☐ Knee: left/right
☐ other: _____

HEAD/NECK

☐ Headaches
How often? _____
☐ Migraines
How often? _____
☐ Vision problems
☐ Contact lenses
☐ Glasses
☐ Earaches

CARDIOVASCULAR

☐ High BP
☐ Low BP
☐ Poor circulation
☐ Heart disease
☐ shortness of breath
☐ Phlebitis
☐ Varicose veins
☐ Stroke / CVA
☐ Pacemaker or Similar device

RESPIRATORY

☐ Chronic cough
☐ Shortness of breath
☐ Smoke _____
(How many? How long?)
☐ Breathing problems
Type: _____
☐ Emphysema

DIGESTIVE/URO-GENITAL

☐ Difficult digestion
☐ Constipation
☐ Liver/Gall bladder

SKIN/INFECTION

☐ Skin conditions
Type: _____
☐ Bruise easily
☐ Hepatitis
☐ TB
☐ HIV
☐ Herpes

OTHER CONDITIONS

☐ Sinus
☐ Allergies
Type: _____
☐ Colds
Frequency: _____
☐ Insomnia
Hours of Sleep: _____
☐ Cancer
Type: _____
☐ Arthritis
Type: _____
☐ Epilepsy
☐ Loss of Sensation
Where: _____
☐ Diabetes

EXERCISE/SPORTS

☐ Regular exercise
Type of activity _____
Times per week _____
Specific training _____
(What event? When?)
☐ Chronic pain/injury
associated with activity
☐ Acute pain/injury
associated with activity

WOMEN ONLY

☐ Menstrual problems
☐ Painful
☐ Heavy
☐ Scant
☐ Pregnant?
Due date: _____
☐ Other Form Filled

ADDITIONAL INFO

☐ Presence of internal pins, wires, artificial joints, etc

_____

_____

I understand that the information that I give on this form will be confidential and will be used for no other purpose than the professional clinical records of this office. I understand that I am required to give **24 HOURS NOTICE** of appointment cancellation or I will be charged the full fee for a missed appointment.

_____
Signature of Client

_____ Date: _____
Therapist

Date of Initial Health History
Update 1
Update 2
Update 3
Update 4

Patient Accepted: ☐YES ☐NO INIT _____

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Massage Therapy

Informed Consent

I hereby request and consent to the performance of massage therapy, hydrotherapy and other remedial exercise therapy performed by a Registered Massage Therapist (from this time forth will be called the RMT) at the Merivale Chiropractic Clinic.

I understand and am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment. These risks include but are not limited to, slight to moderate muscle soreness, tiredness and slight dizziness. I do not expect the RMT to be able to anticipate and explain all risks and complications. I understand that risks to treatment depend on my own health state and may vary accordingly. I wish to rely on the RMT to exercise judgment during the course of the treatment procedure which the RMT feels at the time is in my best interests, based upon the facts then known.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing down below, I agree to the above named procedures. I understand that results are not guaranteed. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

To be completed by patient:

_____ _____

Print Name Patient (or parent/gardian) signature

_____ Date signed: _____

Witness to signature

FOR OFFICE USE ONLY:

_____

_____

_____

_____

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OFFICE POLICIES

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

MASSAGE HOURS:	**Bao Phan, RMT**
Monday:	11:00 am – 06:45 pm
Tuesday:	08:45 am – 03:00 pm
Wednesday:	
Thursday:	
Fridays:	09:45 am – 06:45 pm
Saturday:	

APPOINTMENT SCHEDULING/MISSED APPOINTMENTS

☐ The RMT has designed a specific course of action to allow proper care. If an appointment must be changed, 24 hours notice is needed. All missed appointments should be made up later the same day or within 48 hours. Please let our front desk know and changes will be made accordingly. **Any appointments that are cancelled with less than 24 hours notice will be considered a broken appointment**

LATE APPOINTMENTS

☐ "Late" appointments are subject to full fee of time scheduled. This time is the time available for treatment.

BROKEN APPOINTMENTS

☐ ***"No show" appointments are subject to fee equal to the cost of the booked massage (HST will not be charged). When booking your massage you will be required to provide a credit card number.***
Charges will only apply if 24 hours notice is not provided. This 24 hour notice allows us to provide your time slot to others in need. If appointments are repeatedly missed we will, regretfully, have to dismiss you from care.

FINANCIAL AGREEMENTS

☐ It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings.
If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

INTERRUPTION OF CARE

☐ In the unlikely event it is necessary to discontinue your care for any reason, any outstanding fees become payable and due immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

MASSAGE THERAPY EXCELLENCE

☐ The RMT and the staff are occasionally out of the office to attend seminars and conferences to further their education. We will build your schedule around those times.

REMEMBER

☐ Correction and healing take time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with your RMT. We want you to get the most from your care.

WSIB/ MVA ONLY

☐ I am fully aware that I am responsible for any balances on the account, in the event that your insurance does not approve the treatment plan given by the Therapist.

Signed _____ **Date:** _____

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