Welcome

Personal Information

Name: _____ □ Male □ Female Birth Date: _____ (d/m/y)
Address: _____ City: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Phone # for messages: □ Home □ Work □ Cell Email: _____
Occupation: _____ □ Student □ Retired
Who may I thank for referring you to our office? _____
□ Gift Certificate □ Website □ Facebook □ Other: _____

Privacy Policy

On November 1, 2004, the Personal Health Information Protection Act (PHIPA) came into force. This new law provides the regulations by which healthcare providers collect, use, allow access, and store your personal health information.
Helena Hamm, RMT is committed to respecting and protecting your privacy. Personal identifying information is protected in this office. In accordance with the College of Massage Therapists of Ontario (CMTO), the treating Registered Massage Therapist notes are confidential, will be securely maintained and used to facilitate assessment and therapeutic treatments. Your information will be updated annually to ensure your records are accurate and complete. You will be asked to provide written authorization for the release of any information. Treatment records will be kept at the office of Buzek Chiropractic Clinic for a period of 10 years after your last treatment date or, if under 18 at the time of treatment, records will be kept for 10 years after your 18th birthday. If you need to access, update, or correct your records, please contact the office.

Consent Policy

In order for you to provide informed consent to treatment, at the start of each session, we will discuses any concerns as well as your treatment plan including the benefits, risks, and alternate therapies available for treatment. Massage Therapists provide assessments but not a medical diagnosis. You will be referred to your family physician or an appropriate health care professional when necessary. When explaining a proposed treatment, I will describe the nature of the treatment, the expected benefits, and risks or side effects of the proposed therapy, alternative options, and any consequences of t not having the treatment. **A patient may withdraw or modify consent to treatment at any time, and the request will be respected immediately.**

Receipts

As a Registered Massage Therapist with the College of Massage Therapists of Ontario (CMTO), I will provide an official receipt for each massage therapy treatment. Many extended health plans cover Massage Therapy when provided by a RMT. A referral note from your doctor may be required for coverage. Contact your extended health plan representative to receive the specific coverage your plan offers.

Cancellation, Late Arrival, No Show Policy

If you are unable to attend a scheduled appointment, please call and cancel the appointment a minimum of 12 hours prior. Failure to cancel with proper notice or failure to be present for a schedule appointment will result in being charged the full rate for the missed appointment. As late arrival reduces treatment time, please arrive on time or 5 minutes early. Full session fees will apply when a late arrival does occur.

Massage Therapy Treatment Rates

*all rates include HST

30 Minutes……$47.00
45 Minutes……$62.00
60 Minutes……$80.00
90 Minutes……$115.00
30 Minute Reflexology……$32.00
60 Minute Hot Stone Massage….$95.00

Please sign to indicate that you have read and understand this information.

Patient Signature: _____ **Date:** _____

REGISTERED MASSAGE THERAPY
HEALTH HISTORY FORM

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone: _____
Address: _____
Occupation: _____ Date of Birth: _____
Have you received massage therapy before? □ Yes □ No
If yes, please provide their name and address: _____

Please indicate any conditions you are experiencing or have experienced:

CARDIOVASCULAR
□ High blood pressure
□ Low blood pressure
□ Chronic congestive heart failure
□ Heart Attack
□ Phlebitis/varicose veins
□ Stroke / CVA
□ Pacemaker or similar device
□ Heart Disease

Is there a family history of any of the above?
_____

RESPIRATORY
□ Chronic cough
□ Shortness of breath
□ Bronchitis
□ Asthma
□ Emphysema

Is there a family history of any of the above?
_____

INFECTIONS
□ Hepatitis
□ Skin Conditions
□ TB
□ HIV
□ Herpes

OTHER CONDITIONS
□ Loss of sensation,
_____
□ Diabetes, Onset: _____
□ Allergies/hypersensitivity
_____
Type of reaction: _____
□ Epilepsy
□ Cancer, _____
_____
□ Skin Conditions, _____
_____
□ Arthritis

Is there a family history of arthritis? □ Yes □ No

HEAD/NECK
□ History of headaches
□ History of migraines
□ Vision Problems
□ Vision Loss
□ Ear Problems
□ Hearing Loss

WOMEN
□ Pregnant, Due Date: _____
□ Gynaecological conditions,
_____

Overall, how is your health?
_____

Primary Care Physician
_____
Address
_____
_____

Current Medications:
_____
_____
Condition it treats: _____
_____

Are you currently receiving treatment from another health care professional?
□ Yes □ No If yes, for what? _____
_____

List the dates of significant surgeries and/or injuries
_____
_____
_____
_____

Do you have other medical conditions?
ie: digestive, haemophilia, osteoporosis etc.
_____

Do you have any internal pins, wires, artificial joints or special equipment? □ Yes □ No
What? _____
Where? _____

Why are you seeking massage therapy?
_____
_____
_____
_____

Date of Initial Health Hx_____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

Buzek Chiropractic Clinic
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