Health History Form - Massage Therapy

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

Name: _____ **Phone** _____
First name Last Name home or cell

Address: _____
City Postal Code

Occupation: _____ **Date of Birth:** _____
month / day / year

Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced in the past:

Cardiovascular

___ high blood pressure
___ low blood pressure
___ chronic congestive heart failure
___ heart attack
___ phlebitis / varicose veins
___ strokes / CVA
___ pacemaker or similar device
___ heart disease

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

___ chronic cough
___ shortness of breath
___ bronchitis
___ asthma
___ emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

___ hepatitis
___ skin conditions
___ TB
___ HIV
___ herpes

Other Conditions

___ loss of sensation? Where? _____
___ diabetes, onset _____
___ allergies / hypersensitivity to what? _____
type of reaction: _____
___ epilepsy
___ cancer, where? _____
___ skin condition, what? _____
___ 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, What? _____

Overall how is your general health? _____

Primary Care Physician:
Name and address: _____

Current Medications:

_____
_____
_____
Condition being treated? _____
_____

Have you had surgery? ◯ Yes ◯ No
When: _____
month / day / year
What type of surgery? _____

Are you currently being treated by another health care professional? ☐ Yes ☐ No
if yes, for what? _____

NOTES: _____
_____
_____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoprosis, mental illness)?

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

What is the reason you are seeking massage therapy treatment? Please include the location of any tissue or joint damage.
_____
_____

Initial Health Intake

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

quinnrehab
Trusted Health Professionals Since 1994

505 - 34 Cedar Pointe Drive
Barrie, ON L4N 5R7
phone: 705-726-2362 fax: 705-726-1589

RELEASE OF INFORMATION CONSENT FORM

I, _____ authorize QuinnRehab
Print Patient / Guardian Name

to furnish or obtain all information from _____

_____

including any documents and reports in regards to the condition and treatment of:

_____ _____
Print Patient Name Date of Birth: yyyy / mm / dd

_____ _____
Patient / Guardian Signature Date: yy yy / mm / dd

_____
Patient / Guardian Name (please print)

_____ _____
Witness Signature Date: yy yy / mm / dd

_____
Witness Name (please print)

Returning for treatment - signature update

By signing below, you indicate your continued agreement within the terms of this document.

Update #1: _____ _____ _____
Patient / Guardian Signature Date: yy /mm / dd Witness Signature

Update#2: _____ _____ _____
Patient / Guardian Signature Date: yy /mm / dd Witness Signature

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Guiding Principles, Privacy & Cancellation Policy

Quinn Rehab (QR) endorses and strives for an inclusive environment, one that demonstrates respect, equity, and support for all individuals, regardless of race, ethnicity, gender identity, age, faith, ability, or sexual orientation. QR implements a top to bottom approach to achieve a welcoming environment for all, validated through words and actions.

On January 1, 2004, the Personal Information Protection and Electronic Documents Act (The Act) came into effect with a mandate to balance the privacy rights of the individual and the needs of commercial organizations to collect information for business purposes.

QR remains committed to you, to your health, and respects your right to confidentiality. The privacy policy of **QR** is founded on the following principles:

ACCOUNTABILITY: The staff of **QR** are responsible for maintaining and protecting all information collected by the clinic. Patty Staring, Privacy Officer for **QR** would be pleased to speak with you if you require any clarification.

LIMITED AND ACCURATE COLLECTION OF INFORMATION: QR limits the collection of personal information to that which is necessary for the provision of excellence in health care. This information is accurately maintained in its most current form to fulfill the purposes for which it was collected.

CONSENT: A decision to receive care at **QR** implies consent for the sharing of information internally, for purposes related to your health care only. Written consent is required from you to share your health care information externally. You may withdraw this consent in writing at any time.

TELE-REHABILITATION: If you and your therapist have determined that care delivered via an online platform is appropriate, the platform will be secure and encrypted to protect your privacy. In addition, there is a mutual understanding that online care has limitations associated with an inability to perform hands-on assessments, examinations, and treatments. In the case of failure of video transmission, please call the clinic at 705-726-2362.

DISCLOSURE AND RETENTION: Patient information is kept in a secure manner for a period of ten years. This information will only be utilized for the purposes for which it was collected or if required by law.

INFORMATION STORAGE: Appropriate security measures are utilized to secure the privacy of all information collected in the delivery of your health care services.

PATIENT ACCESS: You are entitled to view the information collected by **QR** regarding yourself. You may obtain a copy of your records. There is a fee for this service.

I hereby consent to the collection, use, maintenance, and disclosure of my personal information as indicated above, unless and until I withdraw consent in writing.

CANCELLATION POLICY

Please be aware that 24 hours' notice is required for an appointment cancellation, or you will be charged the full fee. NOTE: INSURANCE COMPANIES DO NOT PAY FOR AN UNCANCELLED APPOINTMENT.

_____	_____	_____
Date	**Name (please print)**	**Signature**

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Quinn Rehab is a private rehabilitation clinic. All therapists are licensed to practice their respective professions in Ontario. For more information about our therapists, please go to our website (www.quinnrehab.com).

Physiotherapy	**Assessment**	**60 Minutes**	**$140.00**
	Assessment	**30 Minutes**	**$79.00**
	Treatment	60 Minutes	$140.00
	Treatment	45 Minutes	$115.00
	Treatment	30 Minutes	$79.00
	Treatment	15 Minutes	$48.00
Osteopathy	**Assessment**	**60 Minutes**	**$130.00 + HST**
	Assessment	**30 Minutes**	**$72.00 + HST**
	Treatment	60 Minutes	$130.00 **+ HST**
	Treatment	45 Minutes	$105.00 **+ HST**
	Treatment	30 Minutes	$72.00 **+ HST**
Athletic Therapy	**Assessment**	**60 Minutes**	**$130.00 + HST**
	Assessment	**30 Minutes**	**$72.00 + HST**
	Treatment	60 Minutes	$130.00 **+ HST**
	Treatment	45 Minutes	$105.00 **+ HST**
	Treatment	30 Minutes	$72.00 **+ HST**
Massage Therapy	**Assessment**	**60 Minutes**	**$90.00 + HST**
	Treatment	60 Minutes	$90.00 + HST
	Treatment	45 Minutes	$70.00 + HST
	Treatment	30 Minutes	$55.00 + HST

Completion of forms: Insurance, WSIB, Accessibility Parking Permit, Return to Work/School notes or forms. This does not include medical report/letters. **Prepayment is required**. …… **$45.00**

Motor Vehicle Collision Insurance: Please note that you may be asked to pay the difference in fees related to professional services that exceed the maximum hourly rates set out in the Financial Services Commission of Ontario 2014 Professional Services Guideline. Please ask your therapist for more information if this applies to you.

Payment: Payment methods include cash, cheque, MasterCard, Visa, and Interac. Accounts are payable at time of appointment. A service charge of 5% will be added to all overdue accounts. There is a $50.00 service charge for NSF cheques.

_____ _____ _____

Date **Name (please print)** **Signature**