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

Occupation: _____ **Date of Birth:** _____ Postal Code
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

QuinnRehab (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 Electronics Documents Act (The Act) came into effect with a mandate to balance the privacy rights of the individual and the needs of commercial organization 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** is responsible for maintaining and protecting all information collected by the clinic. Patty Staring, Privacy Officer for **QR** would be pleased to speak to 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 excellent health care. This information is accurately maintained in its most current form in order 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 in order to share your health care information externally. You may withdraw this consent in writing at any time.

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 advise 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.

Date	Name (please print)	Signature	Witness