Ottawa Chiropractic and Sports Injury Clinic

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:

Cardiovascular	Infections	Head/Neck
High blood pressure	Hepatitis	History of headaches
Low blood pressure	Skin conditions	History of migraines
Chronic congestive heart failure	TB	Vision problems
Heart attack	HIV	Vision loss
Phlebitis/ varicose veins	Herpes	Ear problems
Stroke/CVA		Hearing loss
Pacemaker or similar device	Other conditions	
Heart disease		Women
	Loss of sensation, where?	Pregnant, due:
Respiratory	_____	Gynecological conditions, what?
Chronic cough	Diabetes, onset::_____	
Shortness of breath	Allergies/hypersensitivity to what?_____	Overall, how is your general health?
Bronchitis	Type of reaction:	
Asthma		
Emphysema	Epilepsy	
	Cancer, where?	
Is there a family history of any of the above? Yes / No	Skin condition, what?	
	Arthritis	
	Is there a family history of arthritis? Yes / No	

Current Medications: _____ Condition it treats: _____ Are you currently receiving treatment from another health care professional? Yes No If yes, for what? _____ Surgery- date: _____ Nature: _____ Injury- date:_____ Nature: _____	Do you have any other medical conditions? (ie. Digestive conditions, hemophilia, osteoporosis, mental illness) Yes/ No What? _____ 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? Please include the location of any tissue or joint discomfort. _____ _____

Date of Initial Health History

Update 1: _____

Update 2: _____

Update 3: _____

Update 4: _____

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.

Ottawa Chiropractic and Sports Injury Clinic

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 _____