FRONTENAC CHIROPRACTIC and Sports Rehab

Chiropractic Treatments

Consultation/Examination with Treatment	$85.00
Chiropractic Subsequent Visit	$45.00*
Reassessment	$70.00
Acupuncture Visit	$55.00*
Concussion-Baseline/Re-Evaluation	$80.00
Concussion Treatment	$55.00
Custom Orthotics	$500.00

*$5.00 Student & 65+ Seniors' Discount on select services

Registered Massage Therapy (HST incl.)

30 Minute	$60.00
45 Minute	$75.00
60 Minute	$90.00
90 Minute	$130.00

Missed Appointment and Cancellation Policy

If you are unable to keep a scheduled appointment, please give 24 hours advance notice, to ensure that you will not be charged for the appointment.
If less than 24 hours noticed is given, you will be expected to pay for the appointment.

Health Insurance/Payment: *Many insurance companies have benefits covering all or part of your chiropractic and/or massage care. It is best to check your coverage to determine if you have these benefits. Direct billing is available for some companies and some policies. Payment for the cash portion of your bill is expected the day of treatment.*

2785 Princess Street
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Health History and Consent for Massage Therapy

Please take a moment to fill out this health history form as completely as possible. The information gathered through your health history provides your massage therapist with necessary information to treat you safely. Please feel free to ask questions about why we are requesting this information. The information you provide us with will be kept confidential unless you submit a written request for us to release your information or if required by law.

Patient Profile

Date: _____ **Date of Birth**: **(D)** _____ **(M)** _____ **(Y)**_____

Name: _____ **Home or Cell Phone:** _____

Address: _____ **Work Phone**: _____

City: _____ **Email:** _____

Postal Code: _____ **Age:** _____

Height: _____ **Weight:** _____

Occupation: _____

Emergency Contact Name: _____**Phone**: _____

Have you received massage therapy before? **?** _____Y _____N

Were you referred for massage therapy from a health care practitioner? **?** _____Y _____N

If yes, please provide their name and address: _____

What is your primary complaint?_____

Can you describe it? (circle one or more) DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Pain scale: (low) 1----------5----------10 (high) Does the pain radiate anywhere?_____

Does anything aggravate your symptoms?_____

Does anything relieve your symptoms?_____

When did your symptoms begin?_____

Have they changed & how?_____

Has anyone in your family experienced these symptoms? **?** _____Y _____N

If so, their relationship to you_____

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Is this condition interfering with (check all that apply): ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ ACTIVITIES

(Please explain)_____

Have you seen any other health care practitioner concerning this complaint? Medical Dr ☐ Chiropractor ☐

Physiotherapist ☐ Massage Therapist ☐ Have they provided results?_____

Surgery/injuries/hospitalization: (date, past & current symptoms)_____

_____

Do you have any internal pins/wires/artificial joints?_____

Are you currently taking any medications?: (please list them and the condition they treat)_____

_____

Lifestyle:

Energy levels (circle): Low Average High

Do you feel stressed? _____Y _____N Cause? _____

Regular exercise? _____Y _____N Type_____ Frequency_____

Regular sleep habits? **?** _____Y _____N

Computer use? **?** _____Y _____N How many hours per day_____

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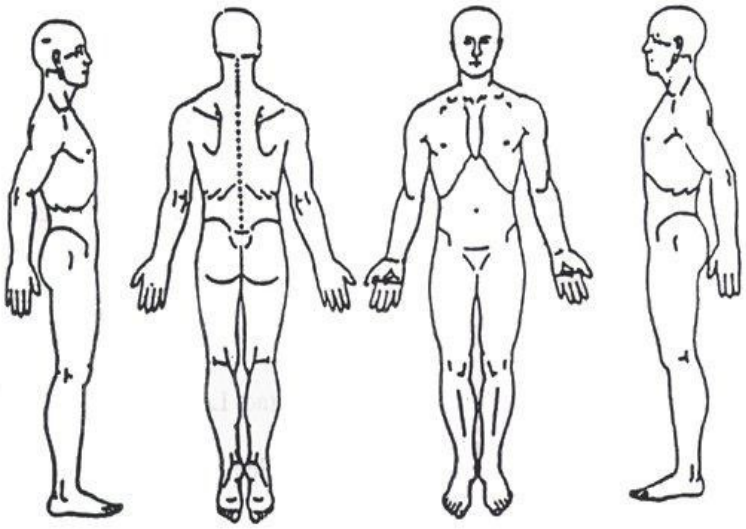
Please indicate on the diagram below the location(s) of your symptoms:



Have you or any of your blood relatives experienced any of the following conditions? If so, please indicate which ones:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoker?

Head and Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems

Soft Tissue/Joint Pain

- ☐ Neck
- ☐ Upper back/shoulders
- ☐ Arms/hands
- ☐ Mid back
- ☐ Low back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Other _____

Infections

- ☐ Hepatitis
- ☐ Skin conditions/rash
- ☐ TB
- ☐ HIV
- ☐ Herpes

Women

- ☐ Pregnant. Due:
- ☐ Gynaecological issues.
  What:_____
  _____

Other

- ☐ Loss of sensation. Where:_____
- ☐ Diabetes. Onset: _____
- ☐ Allergies. To what:_____
- ☐ Epilepsy
- ☐ Cancer. Where:_____
- ☐ Fibromyalgia
- ☐ Swelling in the ankles
- ☐ Bruise easily
- ☐ Arthritis
- ☐ Digestive conditions
- ☐ Hemophilia
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Dizziness/Fainting
- ☐ Other:_____
  _____

Gastrointestinal

- ☐ Diarrhea
- ☐ Indigestion/heartburn
- ☐ Constipation
- ☐ Other:_____

How would you rate your overall health? (Circle) ☐ Fair ☐ Good ☐ Excellent

What are your goals for your massage therapy treatment? _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand the cancellation policy, and that I must provide at least 24 hours' notice of cancellation of an appointment. I understand that I may be charged the full fee for a missed appointment if proper cancellation notification is not provided to the clinic.

Client Name _____ Signature of Client/Guardian _____

Therapist name_____ Date Signed _____

Notes:

Date of initial health history: _____

Update 1_____

Update 2_____

Update 3_____

Update 4_____