



NEW PATIENT i n f o r m a t i o n

10592 Wellington Road, St. Thomas, ON N5P 3T1
519-633-2585

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PERSONAL HEALTH INFORMATION PROTECTION ACT (P.H.I.P.A.)

WHAT ARE YOUR RIGHTS?

P.H.I.P.A. gives you the right to;

- Give permission (consent) to how your personal health information is collected, used, and shared.
- Request access to your health records.
- Make corrections to your records.

- STEP #1** You are required to fill out a personal history questionnaire.
- STEP #2** You will be advised concerning financial arrangements and/or insurance coverage as appropriate.
- STEP #3** As part of your treatment the therapist will discuss with you, your health concerns.
- STEP #4** Muscle examination and neuromuscular tests will be done (with your permission) as related to massage therapy to determine treatment.
- STEP #5** I _____ have given the massage therapist permission to assess and treat the affected areas, using direct hands on manipulation techniques, as well as other applicable modalities (i.e.. heat, ice packs, ultrasound, remedial exercises, etc.). I also realize I can stop treatment at any time.

Signature: _____

STEP #6 You will be properly draped during treatment, with only the area being treated/massaged uncovered. Treatment will begin and continue as scheduled until maximum correction for you has been obtained.

STEP #7 Insurance Coverage and Treatment Cancellation Policies

- A) I understand and agree to the health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the therapist will prepare and charge for any necessary reports and forms to assist in the collection of insurance payments. I understand that I am personally responsible for payment of all treatments.
- B) I also understand that I need to give 12 hours notice to cancel or change my reserved appointment time or a fee will be billed equal to the amount of the service.

**Initial
& Date:** _____

PERSONAL HISTORY

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home # _____ Business # _____

Birthdate: _____ Age: _____ Sex: F M Height: _____ Weight: _____

Business/Employer: _____ Type of Work: _____

Emergency Contact Name & Number: _____

Referred to this office by: _____

CURRENT HEALTH CONDITION

Purpose for this Appointment: _____

Family Doctor: _____ Other: _____

Doctor's Address: _____

When did this condition begin? _____

Are there others in your family with this condition? _____

If disabled from work, please give details: _____

What Medications do you take? _____

PAST HEALTH HISTORY

Surgery/Operation: Appendix Tonsils Gallbladder Hernia Heart Back Neck Leg

Hysterectomy Joint Replacement Other: _____

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DO NOT WRITE IN THE BOX BELOW

Therapist Signature

FOR THERAPIST USE ONLY

ALLERGIES: _____

PLEASE INDICATE THE CONDITIONS YOU ARE, OR HAVE EXPERIENCED

CARDIOVASCULAR:

- High Blood Pressure
- Low Blood Pressure
- CCFF Chronic Congestive
- Heart Failure
- Heart Attack _____
- Phlebitis
- Stroke/CVA
- Other: _____

RESPIRATORY:

- Chronic Cough
- Shortness of Breath
- Bronchitis
- Asthma
- Emphysema
- Pneumonia
- Sinusitis
- Other: _____

HEAD/NECK

- Whiplash
- Migraines
- Vision Problem
- Concussion
- Ringing in Ears
- Hearing Loss
- Other: _____

DIGESTIVE:

- Constipation
- Crohn's Disease
- Irritable Bowel Syndrome
- Ulcers
- Diverticulitis
- Other: _____

SKIN:

- Sensitive Skin
- Irritation/Rashes
- Cold Sores
- Other: _____

INFECTIONS:

- Hepatitis
- Tuberculosis
- HIV/AIDS
- Other: _____

JOINT/MUSCLES:

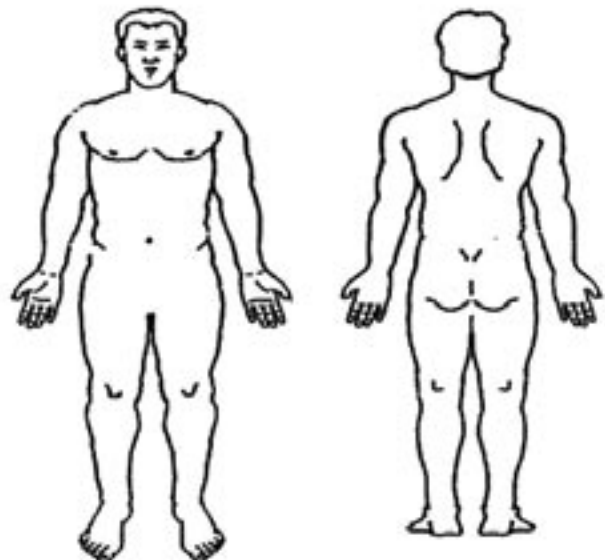
- Neck
- Upper Back
- Mid Back
- Low Back
- Shoulders - right left
- Elbows - right left
- Wrists/Hands - right left
- Hips - right left
- Knees - right left
- Ankles/Foot - right left
- Other: _____

WOMEN:

- Pregnant - Due Date: _____
- Enometriosis
- Dysmenorrhea
- Other: _____

OTHER CONDITIONS:

- Loss of Sensation
- Diabetes - onset _____
- Seizures
- Cancer - _____
- Arthritis (RA/OA) - _____
- Fibromyalgia
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Allergies - _____
- _____
- _____
- Other: _____



Please outline on the diagram all the area(s) of your discomfort.