HEALTH HISTORY FORM

How did you hear about our clinic?
Yellow Pages ______Website ______Our sign______ Facebook______Other?_____________
Family/Friend/Co-Worker___ WHO?_______________________________
Permission to acknowledge the person who referred you________(Initials)

Name:_______________________________________ Date:________________________
Address:________________________________ Telephone:(Home)______________________
City:______________________ Postal Code:_____________ (Cell)______________________
(Work)_____________________
Occupation:_____________________________ Company:_______________________________
Email Address:______________________________ Date of Birth(mm/dd/yy)_______________
Emergency Contact:______________________________ Telephone:____________________
Do you have Extended Health Care Insurance Coverage for Massage Therapy? Yes No
Company Name:___________________________ Policy Number:_________________________
Doctor's Name:________________________________Telephone #:_________________________
Permission to consult with your Doctor: Yes No Initials:_________________________

Primary Complaint?________________________ Aggravates/Relieves?_____________________
Have you seen a Doctor for this problem? Yes No When?____________________________
Overall, how is your general health?____

Please indicate conditions you are experiencing or have experienced:

Respiratory
Chronic Cough
Shortness of Breath
Sinus Problems
Emphysema
Asthma
Allergies
Other________________

Cardiovascular
High/Low Blood Pressure
Blood Clots
Heart Disease/Heart Failure
Myocardial Infarction
Stroke/CVA
Pacemaker or similar device
Other_________________

Digestive
Constipation/Diarrhea
Gas/Bloating
IBS
Other_______________

Nervous System
Herpes/Shingles
Numbness/Tingling
Where?____________
Chronic Pain
Loss of Sensation
Where?_____________
Other_______________

Musculo-Skeletal
Bone or Joint Disease
Arthritis-Type______________
Family Hx:________________
Tendonitis
Bursitis
Sprains/Strains
Low back/Hip/Leg pain
Neck/Shoulder/Arm pain
Jaw Pain/TMJ
Other:_______________________

Reproductive
Pregnant
Due Date:________________
Gynaecological:____________

Other
Hepatitis
Depression
Diabetes-Type________
Vision/Hearing Loss
Headaches/Migraines
Epilepsy
Kidney Disease_______
Other:______________

Infections:
Allergies- ______________
TB
HIV/AIDS
Other:________________
Eczema/Psoriasis

Skin
Bruise Easily
Allergy to creams/lotions
Athletes Foot
Warts
CFS/Fibromyalgia
Other:__________________
Cancer-_____________

Please turn over and complete other side⇒

Current Medications, Vitamins, Herbal Remedies & Conditions they treat:
Name:______________________________ Condition:____
Name:______________________________ Condition:____
Name:______________________________ Condition:____
Name:______________________________ Condition:____

Surgeries and Approximate Date:
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________
Surgery:____ Date:_________________________

Motor Vehicle Accidents and Date
Accident & Injuries:____________________________________ Date:_________________________
Accident & Injuries:____________________________________ Date:_________________________

Other Accidents and Injuries:_____________________________ Date:_________________________
Presence of Internal Pins, Wires, Artificial Joints, Special Equipment, Etc.:___________________________

Other Therapies (Massage Therapy, Chiropractic, Physiotherapy etc.):_______________________________________

Do you have any other conditions not listed or is there anything about yourself you feel would be important for your Therapist to know:____

Please check the body parts you consent to be treated:
Head/Face___ Neck___ Shoulders/Arms___ Hips___ Legs___ Buttocks___ Abdomen___ Inner Thigh___

Consent Form:

It is important that you fill out this health history form to ensure that it is safe for you to receive treatment. If your health status changes please notify your therapist before your next treatment. All information gathered will be kept confidential except as required by law or to facilitate an assessment or treatment. Written authorization from you will be required before any information is released.

I agree to communicate with my therapist at any time if I have questions, if I feel uncomfortable, or if I feel my well-being is being compromised. I will give consent to my massage therapist to treat only on the areas of my body we discussed in the treatment plan. This may include sensitive areas such as gluteals/buttocks, breast/chest wall and upper inner thigh, if necessary. **Initials_________**

I am aware that I may remove only the clothing that I am comfortable removing. I know that I have the right to stop or modify the treatment at any time. It is my choice to receive massage therapy. I understand that Registered Massage Therapists do not diagnose illness, disease or any mental or physical disorder; nor do they prescribe medical treatment or pharmaceuticals. **Initials________**

Cancellation Policy: There is a $25.00 charge for the first missed appointment, or appointments cancelled with less than 24 hrs notice. There will be a full treatment charge for the 2nd and subsequent missed appointments. The 30-75 min. time slot is reserved specifically for you. If you are unable to keep your appointment please notify the office at least 24 hrs before your appointment to enable others to attend a treatment. If you are receiving treatment resulting from an automobile accident that is covered by an insurance claim, any missed appointments will be billed to you personally.

Signature:____ Date:_________________________
Parent/Guardian Signature:________________________________ Date:_________________________
(if under 16 years of age)

Permission Form:

I, ___________________________________ give permission for the clinic of Niagara Therapeutics Inc.to send informational material via mail or email. Personal Information collected by the clinic will not be used for any other purposes. Yes No
My email address is:____
Signature:____Date:_______________________________

For office use only:
History:____________________
Update 1:___________________ Update 2:_______________________Update 3:________________________

Niagara Therapeutics Privacy Policy

Niagara Therapeutics Inc._Massage Therapy and Wellness Clinic provides registered massage therapy. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide.

Niagara Therapeutics may collect personal information as required for services offered through electronic forms, email, phone, fax or in person. This personal information relates to:

1) An individual's personal characteristics (gender, age, home address, phone number, email address)
2) An individual's health (health history, current health status, physicians you are currently seeing)
3) An Individuals activities (sports, hobbies)

Business information although different from personal information and is not protected by privacy legislation, at Niagara Therapeutics your Business Information is treated like personal and will be used responsibly.

Canada's NEW Anti-Spam Legislation:

Effective July 1st, 2014, new legislation came into effect requiring businesses to obtain consent either written or orally, record when it was obtained, why it was obtained and the matter in which it is was obtained before sending electronic messages. Niagara Therapeutics uses the following electronic messages: email. This consent is recorded, dated and maintained by Niagara Therapeutics Inc. We require this consent so we may confirm appointments, send reminder messages and occasionally send out newsletter material via email. This consent is maintained until you withdraw your consent. You can withdraw your consent at any time at the bottom of any newsletter or in person by appointment at Niagara Therapeutics Inc. If you have any questions please feel free to contact our Privacy Officer.

Purpose of collecting your information

We collect, use and disclose information for purposes related to offering you Massage Therapy. Like all medical professionals, we collect, use and disclose personal information in order to serve our clients in the course of Registered Massage Therapy treatment. The primary purpose for collecting personal information is to provide treatment to our clients. For example, we collect information about a client's health history, including their family history, physical condition, function and social situation in order to help us assess what their health needs are, to advise them of their options and then to provide the health care they choose to have. A second primary purpose is to obtain a baseline of health and social information so that in providing on going health services we can identify changes that occur over time.

Other examples of these purposes are as follows:

1) Registered Massage Therapists are regulated by The College of Massage Therapy. The College may inspect our records and interview our staff as part of their regulatory activities in the public's interest.

2) Our College requires us to retain our client records for a minimum of 10 years after the last contact.

Protecting your personal information

Niagara Therapeutics understands the importance of protecting personal information. For that reason, we take the following steps.

1) Paper information is either under supervision or secured in a locked or restricted area.

2) Electronic hardware is either under supervision or is in a locked or restricted area. Computers/tablets are password protected.

Access to your information

With only a few exceptions, you have the right to see what personal information we hold about you. It is our policy to help you identify what records we might have about you. We will also help you understand any information you do not understand (short forms, technical language, etc.) We reserve the right to charge a nominal fee for such requests. If you believe there is a mistake in the information, you have the right to ask for it to be corrected. This applies to factual information and not to any professional opinions we may have formed. We may ask you to provide documentation that our files are wrong. Where we agree that we made a mistake, we will make the correction. If we do not agree that a mistake has been made, we will still include a brief statement in your file that you do not agree with our information.

QUESTIONS

Please contact Niagara Therapeutics Inc with your questions or concerns.

503 Niagara St, Unt #1
Welland, On
L3C 1L7
Tel: 905-788-3214
info@niagaratherapeutics.com

If you wish to make a formal complaint about our Privacy Practices, you may make it in writing to the above address. We will acknowledge receipt of your complaint; ensure that it is investigated promptly and that you are provided with a formal written decision with reasons.

If you have a concern about the professionalism or competence of our services or the mental or physical capacity of any of our professional staff we would ask you to discuss those concerns with us. However, if we cannot satisfy your concerns, you are entitled to complain to our regulatory body:

College of Massage Therapy of Ontario
1867 Yonge Street, Suite 810
Toronto, Ontario M4S 1Y5
Canada

Telephone: 416-489-2626
Toll-free (in Ontario): 1-800-465-1933
Fax: 416-489-2625
E-mail: cmto@cmto.com (general enquiries and for information regarding Public Register) or professionalconduct@cmto.com

Name:____ Date:___________________________

Witness: ____ Date: ___________________________