M & Y Chiropractic Health and Wellness Centre
Confidential Health History Form

Date: _____

Name: _____ Date of Birth: (d/m/y) _____/_____/_____

Address: _____ Unit #: _____

City: _____ Prov.: _____ Postal Code: _____

Telephone: res: _____ bus: _____ cell: _____

E-mail address: _____

What is primary complaint? _____

How were you referred to our clinic? _____

HEALTH HISTORY: Please indicate conditions you are currently experiencing, or have experienced

RESPIRATORY

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

OTHER CONDITIONS

- ☐ Loss of sensation
- ☐ Diabetes (onset: _____)
- ☐ Arthritis (type: _____)
- ☐ Epilepsy (type: _____)
- ☐ Cancer (where: _____)
- ☐ Allergies (type: _____)

WOMEN

- ☐ Pregnant (due: _____)
- ☐ Breast pain
- ☐ Menstrual problems
- ☐ Menopause

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ CCHF
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Varicose veins (where: _____)

HEAD/NECK

- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss
- ☐ Headaches

SOFT TISSUE/JOINT DISCOMFORT (describe)

- ☐ Neck: _____
- ☐ Low back: _____
- ☐ Mid back: _____
- ☐ Upper back: _____
- ☐ Shoulders: _____
- ☐ Arms: _____
- ☐ Legs: _____
- ☐ Knees: _____
- ☐ Other: _____

SKIN

- ☐ Skin condition:_____
- ☐ Bruise easily
- ☐ Shingles (where: _____)

INFECTIONS

- ☐ Hepatitis (type:_____)
- ☐ Skin conditions (type: _____)
- ☐ Tuberculosis (where: _____)
- ☐ HIV/AIDS

WHAT IS YOUR HEALTH STATUS?

_____
_____
_____
_____

Current Medications: _____ Primary Care Physician: _____
Condition it treats: _____ Telephone: _____
Surgery: Nature: _____ Present Involvement in Other Health Care: ☐ yes ☐ no
Date: _____ If yes, please specify: _____
Injury: Nature: _____ _____
Date: _____ _____

Other Medical Conditions (e.g. digestive, gynecological conditions, hemophilia, etc.):

Of Special Note (e.g. presence of internal pins, wires, artificial joints, special equipment):

REGISTERED MASSAGE THERAPY FEES

½ Hour	$60.00	**¾ Hour**	$78.00
	1 Hour	$90.00	
1 ½ Hour	$132.00	**2 Hour**	$180.00

Rescheduled & Missed Appointments without 24 hours notice will result in the full fee for that scheduled time being charged to the patient.

*****Includes HST*****

Please read carefully, and sign.

An accurate health history is important to assist in treating you safely. Feel free to ask any questions about the information being requested. If your health status changes in the future, please let us know.

I attest that the information I have provided is true and complete to the best of my knowledge. I also understand that the information on this form is confidential and will not be released without my written consent, unless allowed or required by law. I will be asked to provide written authorization for release of any information.

I acknowledge that I am responsible for any charges incurred in the course of my treatment and understand that a minimum of 24 hours notice is required to reschedule or cancel any appointment or a charge of the full fee for the appointment time booked will apply.

Massage Therapy is most fully experienced without clothing. However, if you are uncomfortable with this, it is totally up to your discretion and comfort, what you leave on. You will be covered completely with a sheet except for the area that is being worked on. All massages are **strictly therapeutic and non-sexual**. If any area that is being worked on is uncomfortable, you have the right to change your mind and ask the therapist to stop. ***Good communication is the key for your therapist in working within your comfort zone.***

I, as the client have the right to stop, clarify and ask questions about the massage. I also have the right to discontinue treatment at any time. I understand that the information I have provided on this form will remain confidential and will be used for no other purpose than the professional therapist's records.

I also understand that it is the therapist's right to discontinue treatment at any time and for any reason.

Signature: _____ Date: _____

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OFFICE POLICIES FOR PATIENTS

It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

UPON ARRIVAL

Please remove your shoes and check in at front desk. Fill out any necessary forms and return them to front desk. One of our health team members will escort or direct you to your adjusting or treatment room.

Chiropractic – Once you are in an adjustment room please empty your pockets (keys, wallet etc.) and remove any earrings and long necklaces. **Please lie face down on the table as this will relax your muscles and take the stress of gravity off your spine thus facilitating a more comfortable adjustment.**

Registered Massage Therapy, Naturopathic Medicine and Alternative Therapies – Once in your treatment room your practitioner will discuss treatments for the session. This may include areas to be treated, your position on the table, benefits/risks, today's goals and a verbal consent will be obtained before the treatment commences. If you want to change or refuse any part of the treatment at any time you have the right to do so. Your practitioner will then leave the room so that you may undress if necessary and re-enter the room once you are ready. You are covered with sheets at all times; only the area being worked on will be uncovered.

After the treatment your practitioner will suggest a treatment schedule to best suit your individual situation. They may also recommend after care exercises or stretching to further enhance your treatments. You may be asked to complete some paperwork between your treatments to allow your practitioner to fully understand the nature of your issues. Those who follow these recommendations notice better and longer lasting results.

YOUR SCHEDULE

Your specific course of care has been designed just for you by your Health Care Provider and your appointment time has been set aside specifically for you. The importance of keeping your appointments and being on time is crucial to help make our office as efficient as possible for the benefit of all our patients. If you do need to reschedule an appointment we require a minimum of 24 hours notice. Any missed appointments or cancellations without adequate notice may result in a fee being charged to you. Due to the healing nature of your treatments, we request that any missed or cancelled sessions be made up at the earliest available time, ideally within 24 hours. Please understand that as a patient you are responsible for any and all charges incurred during the course of your treatment at our wellness centre. When seeing multiple health team members we will do our best to align your appointments together because we value your time as well. If requested, a personal appointment calendar can be supplied to you.

REFERRALS

Once you understand the importance and benefits provided by each of our Health Care Providers, we are confident that you will want everyone in your family checked. The nicest compliment you can give our clinic is to refer us to your family and friends. Please free to ask anyone on our health team for any literature you may require.

Welcome to our Health and Wellness Family.

I agree and understand the above policies. Signed_____

16775 Yonge St. Ste 214 Newmarket, ON. L3Y 8J4 (905) 898-6644

Consent to Collect and Release Information

M&Y Chiropractic Health and Wellness Centre
16775 Yonge St. Suite 214, Newmarket, ON, L3Y8J4
905-898-6644

I_____, or my appointed representative_____
Print Print

For *M&Y Chiropractic Health and Wellness Centre* to collect and release my general patient medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.
In terms of information, *M&Y Chiropractic Health and Wellness Centre* may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergency or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information
I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions:
_____
_____
_____

□ Consent □ Do not Consent

Patient signature:_____Date:_____

Witnessed:_____Date:_____

Consent to Specific Registered Massage Therapy Treatment

Following a discussion and review of assessment findings,
I, _____ (client name), have requested treatment
by this Registered Massage Therapist, (RMT) _____
(name)
for the treatment of the areas identified below, for the purposes of treating the following clinical indications:
_____
_____

As part of my therapeutic treatment, I am aware that the above named RMT will touch the following area(s) of my body :
[Client to place initials, not check marks, in relevant areas below]

_____ Breast(s)
_____ Chest Wall Muscles
_____ Inner Thigh(s)
_____ Buttocks

The RMT has explained the following to me and I fully understand the proposed treatment including:
[Client to place initials, not check marks, in relevant areas below]

_____ The nature of the assessment, including the clinical reason(s) for treatment of the above area(s) and the draping method used.
_____ The expected benefits of the treatment
_____ The potential risks of the treatment
_____ The potential side effects of the treatment
_____ Alternative courses of action
_____ Likely consequence of not having treatment
_____ That consent is voluntary
_____ That I can withdraw or alter my consent at any time

I voluntarily give my consent for the treatment as discussed and outlined above.
Client Name (print):_____
Client Signature: _____
Date:_____
RMT Signature: _____