Chiro Clinic
PHYSIO & MASSAGE

MASSAGE THERAPY

Confidential Patient Information

Title: ___ Name: _____ Date of Birth: _____ Age: ___ Gender: M / F

Address: _____City: _____Postal Code: _____

Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____

E-mail: _____ Occupation: _____

Medicare #:_____ Do you have Insurance? Yes / No _____

Who recommended you to this clinic? _____

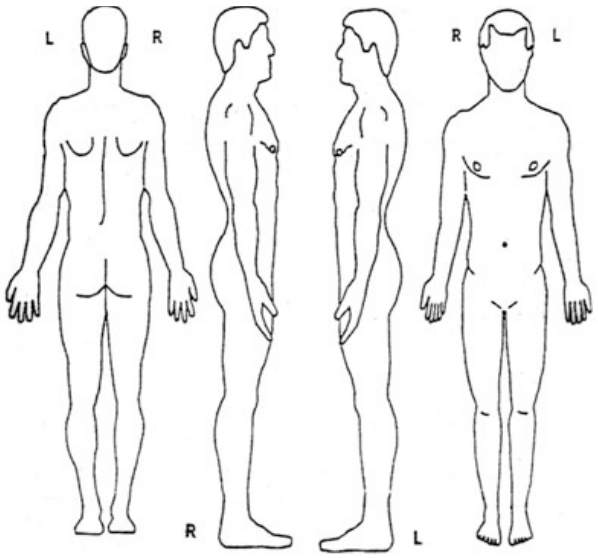
Family Doctor: _____ Clinic: _____

Emergency Contact: _____ Relationship: _____ Ph #: _____

PRIMARY REASON FOR ASSESSMENT: _____

How severe is your pain?

No pain — Worst pain imaginable



How would you describe the problem? _____

What caused your present condition? _____

How long have you had this condition? _____ Where does the pain radiate? □ Arm □ Leg □ Nil

When is the condition worse? □ Morning □ Evening □ During the night Is it waking you at night? □ Yes □ No

Does anything aggravate the condition? □ Lying □ Standing □ Sitting □ Movement □ Other _____

Does anything relieve the condition? □ Yes □ No If yes, please explain _____

The condition is: □ Getting Better □ Getting Worse □ Staying the Same

Have you had Treatment for this condition? □ Yes □ No By Whom: _____ Result: _____

Have you ever consulted a Massage Therapist? □ Yes □ No If yes, when? _____

Have you recently experienced any of the following? (*Please write "Y" for Yes or "N" for No & circle those that apply*)

Fever/Nausea/Vomiting __	Night Pain/Sweats __	Unexplained Weight Loss __
Bowel/Bladder Habit Change __	Difficulty to Speak/Swallow __	Dizziness/Vertigo __
Visual/Hearing Problems __	Fainting/Light-Headedness__	Numbness in Groin Region __

Do you smoke tobacco? Yes / No If yes, how many per day? _____
Do you drink alcohol? Yes / No If yes, how many per day? _____
Do you use recreational drugs? Yes / No If yes, which? _____ How often? _____

Do you have a Pacemaker? Yes / No
Do you take any Medications? Yes / No If yes, which? _____
Do you take any Supplements? Yes / No If yes, which? _____

In your lifetime, have you ever experienced any of the following: (*Please be specific*)

□ Broken Bones: _____

□ Dislocations: _____

□ Infections: _____

□ Hospitalizations: _____

□ Surgeries: _____

□ Cancer/Diabetes/Stroke: _____

□ Other: _____

If you are Female, is there any chance you could be Pregnant? Yes / No / Maybe

Do you engage in regular physical activity? Yes / No If yes, which? _____

How many times per week do you engage in physical activity? _____ Is it high intensity? Yes / No / Rarely

What is the average duration of physical activity? □ <10min □ 10-20min □ 20-30 min □ 30-60 min □ >60 min

Informed Consent to Massage Therapy Treatment

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by governing bodies of massage therapy in New Brunswick. 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. Furthermore, I consent to having my healthcare information stored on protected servers within Canada or abroad.

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.

Date: _____ Name (Please Print): _____ Signature: _____

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Your Privacy: Our Policy

The provision of quality health care requires a relationship of trust and confidentiality. Consistent with our commitment to quality care, Chiro Clinic Moncton has developed a policy to protect patient privacy in compliance with current legislation.

Collection

We will collect information that is necessary to properly treat you. Such necessary information may include;

- Full medical history, family medical history, contact details etc.
- Medicare/private health insurance details and billing/account details

The information will normally be collected directly from you. There may be an occasion when we will need to obtain information from other sources;

- Doctors (I.e. family physicians, chiropractors, and specialists etc)
- Other healthcare providers such as occupational therapists, psychologists, pharmacists, massage therapists, physiotherapists, dentists, hospital and day surgery units etc.
- Rehab practitioners (exercise physiologists, personal trainers, and kinesiologists etc)

Use & Disclosure

With your consent, the practice staff will potentially use and disclose your information for:

- Account keeping and billing purposes for the management of our practice.
- Referral to another medical practitioner or health care provider.
- Clinic updates and newsletters via email.
- Quality assurance, practice accreditation and complaint handling.
- To prevent or lessen a serious threat to an individual's life, health or safety.
- Where legally required to do so, such as producing record to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
- Contacting your next of kin or emergency contact to disclose sensitive information regarding your case in the event of an emergency, as deemed appropriate by the practitioners at this practice.
- Electronic practice management and health record keeping, where information shall be stored on servers located within Canada or abroad.

Consent

I provide my consent for the staff and practitioners at Chiro Clinic Moncton to collect, use and disclose my personal information as outlined above. I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Date: _____ Name (Please Print): _____ Signature: _____