



209 Frederick Street, Suite 102, Kitchener, ON N2H 2M7 • P. 519.342.3123 • F. 519.342.3124
www.handsonhealthcare.ca

Welcome New Patient!

Personal Information

Mr. Mrs. Miss Ms Dr.

Last name: _____ First name and initials: _____

Date of birth: Day _____ Month _____ Year _____ Age: _____

Address: _____

Postal Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Occupation: _____

Healthcare Information

Have you been to a massage therapist before? Yes No If so, who? _____

Family Doctor's Name _____ Telephone () _____

How did you hear about our clinic? Friend Family Member Massage Therapist
 Family Dr. Yellow pages Good Life Gym Chamber of Commerce Magnet
 Website Other _____

Health Information

What is your major health complaint? _____

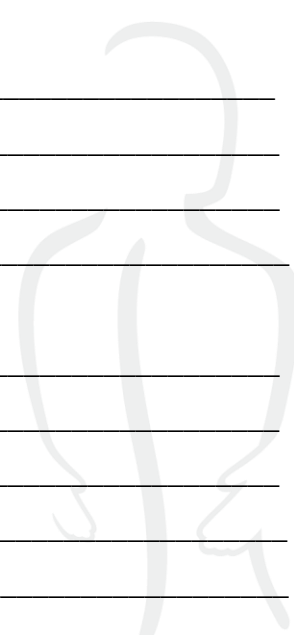
How long has it been present? _____

Did it begin gradually suddenly?

What do you think has caused this problem? _____

What makes your symptoms worse? _____

What makes your symptoms decrease? _____



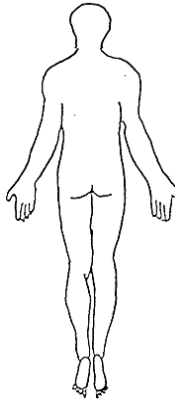
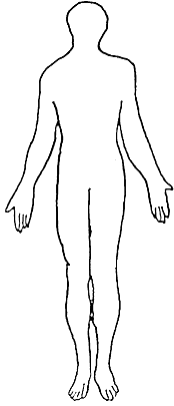
Pain intensity – On a scale of 0-10 with 0 representing no pain and 10 being the worst pain you have ever had, how would you rate your pain? ___/ 10.

Do you have any other health complaints?

Please indicate the area of complaint(s) on the diagrams.

Front

Back



Please mark off the areas of your complaint on the diagrams. Use the following symbols to accurately describe your condition.

PPP – where you experience pain
NNN – where you experience numbness
TTT – where you experience tingling
CCC – where you experience cramping

Right Left Left Right

Have you had any of the following illnesses? (Please ✓ all of these that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hernia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Other Illnesses _____ | | |

In your immediate family (parents, brothers or sisters) is there any history of:

- Stroke Cancer Diabetes Heart Disease Other diseases?

Have you ever been hospitalized? Yes No If so please explain _____

Have you fractured any bones? Yes No If so please explain _____



Please list all surgeries (reason and date) _____

Have you ever been involved in a motor vehicle accident? Yes No If so , when?_____

Do you have any of the following symptoms? (please all that apply)

- | | | | | |
|---|--|--|-------------------------------------|---|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> headaches | <input type="checkbox"/> sprains/ fractures | <input type="checkbox"/> chest pain | <input type="checkbox"/> earaches |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> chronic cough | <input type="checkbox"/> dizziness | <input type="checkbox"/> weakness | <input type="checkbox"/> allergies |
| <input type="checkbox"/> rapid weight changes | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> tremors | <input type="checkbox"/> hip pain | <input type="checkbox"/> muscle spasms |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> blurred vision | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> blackouts | <input type="checkbox"/> frequent urination |
| <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> difficult urination | <input type="checkbox"/> back pain/ stiffness | <input type="checkbox"/> depression | <input type="checkbox"/> chronic fatigue |
| <input type="checkbox"/> swollen joints | <input type="checkbox"/> swollen glands | <input type="checkbox"/> ankle pain | <input type="checkbox"/> knee pain | <input type="checkbox"/> elbow pain |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> wrist/hand pain | <input type="checkbox"/> arm/hand pain or numbness | | |

OTHER SYMPTOMS _____

Have you ever been on birth control ? Yes No Are you currently on birth control? Yes No

List any pills, vitamins or medications: _____

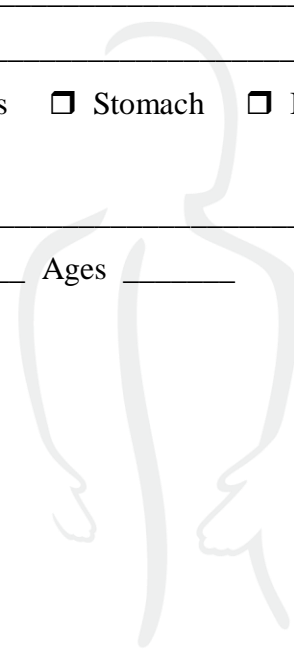
How much do you exercise (type and frequency) _____

In what position do you sleep? Left Side Right Side Both Sides Stomach Back

Do you smoke? Yes No If so, how much? _____

Do you drink alcohol? Yes No If so, how much? _____

of Pregnancies _____ # Miscarriages _____ # Children _____ Ages _____





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Fee Schedule

30 minute treatment: \$60.00

45 minute treatment: \$75.00

60 minute treatment: \$90.00

90 minute Hot Stone \$135.00

Full Payment is expected when service is rendered. Payment can be made by Cash, Cheque, Debit or Visa. Returned cheques are subject to a \$25.00 NSF charge.

PLEASE NOTE:

**Missed appointments, without the notice of 24 hours,
will be charged the full fee of the missed treatment.**

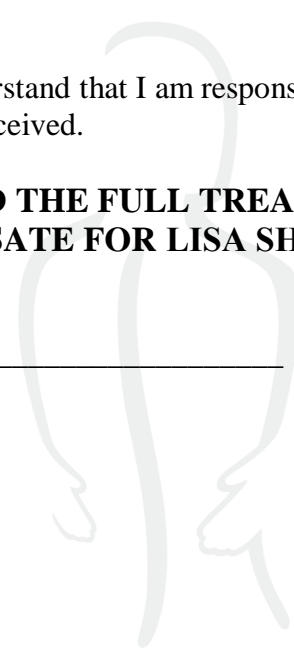
The account is the responsibility of the patient. Workers Safety Insurance Board will be billed directly on your behalf for the charges incurred during treatment. It is the patient's responsibility to submit receipts to group health plans. Check with your health plan to determine details of your coverage.

Consent

I _____ have read the above, and agree and understand that I am responsible for all charges relating to my chiropractic treatment on the day that treatment is received.

**I ALSO UNDERSTAND THAT I WILL BE CHARGED THE FULL TREATMENT FEE,
IF 24 HOURS NOTICE IS NOT GIVEN, TO COMPENSATE FOR LISA SHERK'S TIME.**

Date: _____ Signature: _____



Patient Privacy Consent Form **For Collection, Use and Disclosure of Personal Information**

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

AT HANDS-ON HEALTHCARE, THE PRIVACY INFORMATION OFFICER IS:

DR. DEBORAH HEAMAN

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that

- only necessary information is collected about you
- we only share your information with your consent
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our clinic. Please be assured that every staff person in the clinic is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses And Discloses Patients' Personal Information

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health need's
- to advise you of treatment options
- to enable us to contact you
- to establish/maintain communication with you via telephone, newsletters, postcard reminders etc.
- to offer and provide treatment, care and services
- to communicate with other treating health-care providers, including specialists and referring doctors
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching on an anonymous basis
- to complete and submit claims for third party adjudication and payment in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- to comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' chart and records in a timely fashion for regulatory and monitoring purposes



- to permit potential purchases, practice brokers or advisors to evaluate the practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the office’s insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this patient consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our clinic will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process

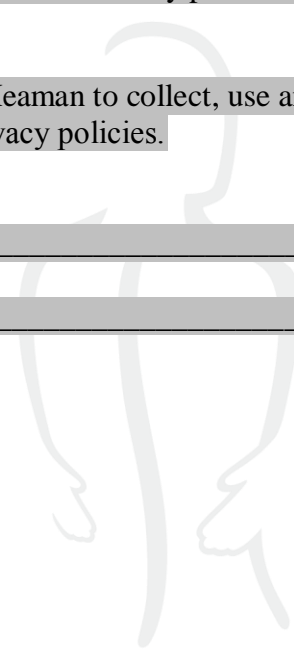
Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I _____ allow Dr. Heaman to collect, use and disclose personal information about me, as set out above in the clinic’s privacy policies.

Signature _____ Print Name _____

Date _____ Signature of Witness _____



MASSAGE THERAPY INFORMED CONSENT

I am aware that this office keeps personal information for identification, communication, treatment safety and effectiveness purposes. I understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the therapist informed of any changes in my health and medication. This is to your benefit as it ensures you will receive the most effective and safest treatment in accordance to your condition. I also understand that under the health information protection act my massage therapist has the right to communicate with other health care providers if the need arises.

I consent to private information to be collected. I also give consent for:

Brief communication about my appointments left on voice mail by personal assistants (reminder calls).

My file may be used for quality audit purposes as dictated by the regulated health professions act and the college of massage therapists of Ontario.

My information may be used as needed in a financial audit situation.

I understand written permission is needed for release of my information to insurance companies and lawyers. In rare cases, I am aware that the legal system may subpoena my records and the therapist is obligated to turn over a copy of my records to the appropriate authorities.

I understand that massage therapy is strictly for therapeutic purposes, including stress reduction, relief from muscular tension, spasm, promotion of circulation, lymph activity, and flexibility. If there is a technique or area that is uncomfortable, you have the right to ask the therapist to stop. I consent to the therapist to use massage therapy techniques and procedures. I also understand that potential risks of massage include: mild, short term muscle soreness due to movement of metabolic wastes; mild surface level bruising. These are normal reactions, and should last no longer then 24 to 48 hours.

During a massage treatment you will be covered with a sheet except the area that is being treated.

Massage therapy is most beneficial without clothing (except for your underpants) but you may undress to your comfort level and the appropriate adaptations will be made.

I understand that massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment, or medications.

I, _____ understand all of the above information, therefore giving consent to be treated. I understand all information is confidential pursuant the ministry regulations.

Client signature: _____ Date: _____

If parent or guardian is signing please state the relationship: _____

No cancellation fee = full amount of session

* I require 24 hour notice should you need to cancel, failure to do so will result in a no cancellation fee in the amount of the full session.

** If you are late for an appointment this does cut into your treatment time as there are other clients to consider.

Lisa Sherk, RMT

