**COVID-19 Screening**

Please fill out quick survey prior to your visit to help everyone stay safe and healthy.

Name: _____ Date: _____

1. Have you travelled outside of Canada in the past 14 days? Yes ◯ No ◯
2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? Yes ◯ No ◯
3. Do you have any of the following symptoms?

- ☐ Decrease/loss of sense of taste or smell
- ☐ Worsening chronic cough
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Runny nose/nasal congestion with no known cause
- ☐ Unexplained fatigue/malaise/muscle aches
- ☐ Nausea/vomiting, diarrhea, abdominal pain
- ☐ New onset of cough
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Headache
- ☐ Pink eye
- ☐ Chills
- ☐ Fever

4. If you are 70 years of age or older, do you have any of the following symptoms?

- ☐ Delirium
- ☐ Unexplained or increased number of falls
- ☐ Acute functional decline
- ☐ Worsening of chronic conditions

- ❖ If you have answered **NO** to all questions and do not exhibit any of the listed symptoms, then you may proceed with your appointment.
- ❖ If you have answered **YES** to any questions or any symptom then you may be asked to reschedule your appointment and further questioning may be required.

**Signature**: _____

By signing above, I certify all information is true and correct to the best of my knowledge.

**THANK YOU**

# HIGHLAND PHYSIOTHERAPY

# HEALTH CONSENT FORM (Massage Therapy)

***We need your informed consent. This means that we need you to understand the services we provide, the costs, and what we do with the personal information we gather about you. Please ask us if you have any questions.***

**CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION**

I understand that to provide me with physiotherapy or massage therapy and services, Highland Physiotherapy (herein known as the company) will collect some personal information about me. (e.g., name, address, phone numbers, and health history).

I have had the opportunity to review The Company's Privacy Policy about the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions I have about the privacy policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to The Company collecting, using, and disclosing personal information about me as set out above and in The Company's Privacy Policy.

**FEE SCHEDULE**

Massage Therapy treatments in our clinic are NOT COVERED BY OHIP. Extended Health Insurance coverage for Massage Therapy is provided by various companies and we advise you to determine if you have such coverage (we will be happy to provide you with invoices so you can submit to your insurance company). If you are seeking Massage Therapy treatment as a result of a W.S.I.B. claim, or Motor Vehicle Accident, please advise us of such and we will initiate the appropriate billing.

However, please be advised that our contract is with you, the patient, and therefore you are ultimately responsible for payment of treatments rendered. This applies to all coverage methods (ie. Extended Health Care, W.S.I.B, and Motor Vehicle Insurance etc…). Please feel free to direct your questions to our staff. We will make every effort to assist you with your claim.

We accept Visa, MasterCard, American Express, Interac, Cheque or Cash.

| | |
|---|---|
| **90 MINUTE MASSAGE** | **$130.00** |
| **60 MINUTE MASSAGE** | **$90.00** |
| **45 MINUTE MASSAGE** | **$80.00** |
| **30 MINUTE MASSAGE** | **$70.00** |
| **MISSED APPOINTMENTS or SHORT NOTICE CANCELS** | **$40.00** |
| **CANCELLED APPOINTMENTS (with 24 HOUR NOTICE)** | **N/C** |

**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 the College of Massage Therapists of Ontario (CMTO).

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 will discuss with my therapist any areas of my body that I am not comfortable with being treated.

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 the results of 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 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 to third party payers.

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.

Name: _____

Signature: _____

Date: _____

Witness: _____

# Health History Form

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

**Personal Information**

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Date of Birth: _____ Email: _____ Height: _____ Weight:_____

Doctor: _____ Phone: _____ May I contact? ○Yes ○No

Emergency Contact Name: _____ Phone: _____

Have you had a massage before? ○Yes ○No For relaxation or other reason?: _____

Current Medications: _____

Previous Major Illnesses, Operations: _____

Accidents (please give dates): _____

_____

Other Medical Conditions (e.g. hemophilia, diabetes): _____

Family history (major illnesses, operations): _____

**Please indicate all conditions you have experienced. Mark C for current or P for past.**

Joint/Soft Tissue Discomfort:

NA Arms
NA Upper Back
NA Mid Back
NA Lower Back
NA Degenerative Discs
NA Feet
NA Hands
NA Hips
NA Jaw
NA Knees
NA Legs
NA Neck
NA Osteo Arthritis
NA Rheumatoid Arthritis
NA Sciatica
NA Shoulders
NA Limitation of Movement in which joints: _____
Other _____

Skin:

NA Rashes
NA Itching
NA Bruise Easily
NA Dryness
NA Boils
Other _____

General Symptoms:

NA Fainting
NA Dizziness
NA Loss of Sleep
NA Fatigue
NA Nervousness
NA Sudden Weight Loss/Gain
C Numbness
NA Tingling
NA Paralysis
NA Headaches (Tension)
NA Migraines

Cardiovascular:

NA High Blood Pressure
NA Low Blood Pressure
NA Coronary Heart Disease
NA Heart Attack
NA Phlebitis
NA Stroke / CVA
NA Pacemaker
NA Heart Murmur
NA Palpitations
NA Varicose Veins
NA Swelling of the Ankles
NA Poor Circulation

Infectious:

NA Hepatitis
NA Tuberculosis
NA Human Immunodeficiency Virus (HIV)
NA Herpes
NA Cold
P Flu
NA Athlete's Foot
NA Warts
Other _____

Digestive:

NA Poor Appetite
NA Belching/Gas
NA Constipation
NA Diarrhea
NA Nausea
NA Ulcer
NA Vomiting

Eye, Ear, Nose, Throat:

NA Allergies
NA Frequent Colds
NA Glasses or Contacts
NA Hearing Aid
NA Hearing Loss
NA Sinus Infection
NA Swollen Glands

(continued on reverse)



**Client Name:**

**Please indicate all conditions you have experienced. Mark C for current or P for past.**

Reproductive:

NA Pregnant
due date _____
NA Painful Menstruation
NA Heavy Flow
NA Irregular Cycle
NA Swollen Breasts
NA Menopausal
NA Pre-menopausal

Respiratory:

NA Chronic Cough
NA Bronchitis
NA Asthma
__ Hay Fever
NA Difficulty Breathing
NA Smoking
NA Emphysema
NA Pneumonia

Lifestyle Questions

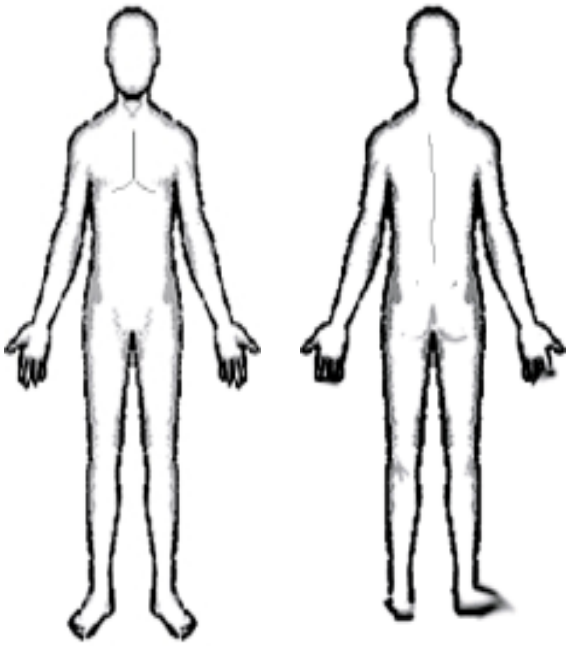
Regular eating habits ○Yes ○No
Do you take vitamins: ○Yes ○No
Type: _____
Frequency: _____
Regular exercise ○Yes ○No
Type: _____
Frequency: _____

Energy Level: ○High ⊙Average ○Low
Do you suffer from stress? ○Yes ○No
Type: _____
Do you use a computer? ○Yes ○No
How many hours per day: _____

Please read carefully, and sign.

I attest that the information I have provided is true and complete to the best of my knowledge.
I understand the information I have provided on this form is confidential and will not be released without my written consent.
I consent to therapeutic massage treatment by the above named massage therapist.
I also understand that I am responsible for any charges incurred in the course of my treatment.
I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

_____ _____
signature today's date



circle any focal areas

This area to be filled out by the therapist.

Duration of Massage: _____ Cost: _____

Techniques Used: _____

_____

_____

Comments: _____

_____

Self Care Recommendations: _____

_____

__ Post-menopausal
__ Birth control
type _____

HHMCA-06/08



**Client Name:**