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COVID-19 Screening **Patient:**______________________

1. Have you tested positive for COVID-19 in the last 21 days or are you waiting on a test result/ Avez-vous eu un test de dépistage positif à la COVID-19 depuis moins de 21 jours ou êtes-vous en attente de résultat d'un test de dépistages?*

__Yes/Oui __No/Non

2. Have you travelled outside of Canada is the past 14 days?/ Est-ce que vous avez voyagé à l'extérieur du Canada dans les 14 derniers jours?

__Yes/Oui __No/Non

3. Do you have any of the following signs or symptoms?/ Présentez-vous les symptômes suivants?

- ☐ Do you have a fever?/ Avez-vous une fièvre (>38°C)
- ☐ New onset of cough/ Toux récente
- ☐ Worsening chronic cough/ Toux chronic qui s'est aggravée
- ☐ Difficulty breathing or shortness of breath/ Difficulté respiratoire nouvelle ou essoufflement
- ☐ New loss or decrease in sense of taste or smell/ Perte récente de l'odorat (anosmie) ou du goût (agueusie)
- ☐ Sore throat/ Mal de gorge
- ☐ Headache/ Mal de tête
- ☐ Loss of appetite/ Perte importante d'appétit
- ☐ Muscle soreness/ Douleurs musculaires
- ☐ Unexplained fatigue or malaise/ Fatigue intense
- ☐ Nausea/vomiting, diarrhea, abdominal pain/ Diarrhée, douleur abdominal, nausea
- ☐ Sneezing (not allergy related)/ Éternuments (pas relier au allergies)
- ☐ Chills/ Frisson

4. Have you had close contact(at least 15 minutes at less than 2 meters apart) with anyone with respiratory illness or a confirmed or probable/suspected case of COVID-19?/ Avez-vous été en contact étroit (au moins 15 minutes à moins de 2 mètres) avec un cas confirmé ou probable de la COVID-19?*

__Yes/Oui __No/Non

5. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures when you had close contact with a suspected or confirmed case of COVID-19?/ Avez-vous porté l'équipement de protection individuelle approprié?

__Yes/Oui __No/Non __Not applicable/ Non applicable

If you have answered "yes" to questions 1, or have checked off signs or symptoms, you may need to reschedule your appointment. If you have answered "yes" to question 3 but "yes" to question 4, you may proceed with your appointment. If you have answered "yes" to questions 1, 2, or have checked off signs or symptoms, you may need to reschedule your appointment. If you have answered "yes" to question 3 but "yes" to question 4, you may proceed with your appointment.

DATE: ______________________ Signature:______________________

Hands-On Integrative Therapy
Massage Therapy | Athletic Therapy | TRX | Kinesiology

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HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.

A 24-hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.

Given Name: ______________________ (*To appear on receipt*)

Family Name: ______________________

Address: ______________________

D.O.B.: MM / DD / YYYY Gender: ______________

City: __________ Prov. ______ Post. Code: __________

Occupation: ______________________

Tel. Home: ______________________

Tel. Bus.: ______________________

Tel. Cell: ______________________

Email: ______________________

Preferred contact: ❑ Tel. Home ❑ Tel. Bus. ❑ Tel. Cell ❑ Email

Preferred Name: ______________________

Do you have a Family Doctor? ❑ Yes ❑ No

Doctor/Clinic Name: ______________________

Address: ______________________

Tel: ______________ Fax: ______________

Emergency Contact: ______________________

Tel: ______________ Relationship: ______________

How did you hear about us?

❑ Friend ❑ Coworker: ______________ ❑ Healthcare Provider: ______________

❑ Other: ______________________

Have you received massage therapy before? ❑ Yes ❑ No

Are you receiving treatment from other healthcare providers?

❑ Chiropractic ❑ Physiotherapy ❑ Acupuncture ❑ Naturopathic ❑ Osteopathy ❑ Other: ______________

Address: ______________________ Tel: ______________ Fax: ______________

Why are you seeking massage therapy today? ______________________

____

Current Medications/Drugs	Reasons/Indications for medication/drug

Soft Tissue/Joints (*Please check and specify*)

Side: *Left (L), Right (R);* **Symptoms:** *Pain (P), Stiffness (St), Numbness (N), Tingling (Ti), Twitching (Tw), Swollen (Sw), Other (O)*

	Present	Past
❑ neck		
❑ shoulder		
❑ upper back		
❑ mid back		
❑ low back		
❑ chest		
❑ arm/hand		
❑ hips		
❑ knees		
❑ legs/feet		

Other current symptoms: ______________________

____

Accident/Injury

Car Accident ❑ Work Related ❑ Other ______________

Date: MM / DD / YY

Physical Limitations: ______________________

____

Surgery

Type: ______________________

Date: MM / DD / YY

Type: ______________________

Date: MM / DD / YY

Type: ______________________

Date: MM / DD / YY

Do you have any pins / wires / prosthetics? ❑ Yes ❑ No

Specify: ______________________

Do you have any contagious or non-contagious skin conditions, rashes, bumps? __Yes/Oui __No/Non

HEALTH HISTORY **Please indicate ☑ conditions you are currently experiencing or have experienced in the past.**

Cardiovascular
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack
  date: MM / DD / YY
- ❑ phlebitis / DVT
  date: MM / DD / YY
- ❑ stroke / CVA
  date: MM / DD / YY
- ❑ pulmonary emboli
- ❑ pacemaker / defibrillator
- ❑ heart disease
- ❑ angina
- ❑ chronic cong. heart failure
- ❑ swelling of ankles

Respiratory
- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems

Gastroinstestinal
- ❑ irritable bowel syndrome
- ❑ colitis
- ❑ gastroenteritis
- ❑ Crohn's disease
- ❑ constipation

Reproductive Health
- ❑ pregnant
  due date: MM / DD / YY
- ❑ gynecological conditions:
  ____
- ❑ breast pain
- ❑ cysts
- ❑ breast lift, augmenta'n, or reduc'n
  date: MM / DD / YY
- ❑ menopause
- ❑ hysterectomy
  date: MM / DD / YY

Mental Health
(if comfortable sharing)
- ❑ depression
- ❑ anxiety/PTSD
- ❑ other: _________________

Face, Head & Neck
- ❑ tooth/jaw/ear pain or TMJ
- ❑ headaches
  type: _________________
- ❑ head trauma
  date: MM / DD / YY
- ❑ vision loss
- ❑ hearing loss

Infectious Disease
- ❑ hepatitis
- ❑ infectious skin conditions
- ❑ herpes
- ❑ tuberculosis
- ❑ HIV
- ❑ other infection:
  ____

Skin
- ❑ skin condition
  type: _________________
- ❑ bruise easily
- ❑ varicose veins
- ❑ athlete's foot
- ❑ loss of sensation
- ❑ skin irritations

Other Conditions
- ❑ positional vertigo
- ❑ neurological conditions:
  ____
- ❑ epilepsy
- ❑ diabetes
  type: ________________
  pump: _____________
- ❑ allergies: _______________
  ____
- ❑ anaphylaxis: _____________
  ____
- ❑ medical alert bracelet
  condition/allergy:
  ____
- ❑ cancer: _________________
  ____
- ❑ arthritis
  type: _________________
  location(s): _____________
- ❑ haemophilia
- ❑ kidney/bladder problems
  type: _________________
- ❑ osteoporosis/osteopenia
- ❑ smoker

Overall, how is your general health: ____

Is there family history of any of the above conditions, health concerns, allergies, or sensitivities (if yes, which?):

____

____

Any other conditions, health concerns, surgeries (old), accidents (old), or injuries (old) not otherwise listed? Please describe:

____

____

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist and will require my informed consent. I understand the 24-hour cancellation policy and agree to pay the missed appointment fee if I cancel within 24 hours preceding my appointment time.

I understand the lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive, and I am ready for my appointment.

Client Signature: ___________________________________ Date: ______________________

UPDATED *(To be revised annually)*

Client Signature: ___________________________________ Date: ______________________

Client Signature: ___________________________________ Date: ______________________

Client Signature: ___________________________________ Date: ______________________

PATIENT CONSENT FORM

Our business is committed to ensure you receive quality informed care and that your privacy is protected. For the duration of your treatment we request your informed consent to:

- Provide assessment and treatment services to you,
- Collect, use, and share any relevant clinical information in providing services to you.

CONSENT TO ASSESS and TREAT

Treatment Information: Massage Therapy (MT) and/or Athletic Therapy (AT) treatment techniques recommended to you may include, but are not limited to: manual techniques, spinal manipulation, therapeutic exercise, electrotherapeutic modalities, therapeutic massage as well as other techniques and procedures your treating RMT/AT determines may improve your function. Your RMT/AT will explain the benefits, side effects and potential complications of each chosen technique before use.

Throughout your recovery program, any questions or concerns you may have about any recommended treatment must be shared with your RMT/AT immediately so they can explain the treatment rationale and/or modify your program appropriately. If at any time you choose not to participate in the course of treatment, please tell your RMT/AT immediately.

I, ________________________, hereby freely consent to participate in the physical and functional assessment and recommended treatment program (based on my medical history, diagnosis, symptoms and assessment results) delivered by those authorized in this clinic, having been informed about the following:

- What to expect in the assessment and treatment;
- Who will be performing the assessment and treatment;
- The reasons why I should have the assessment/treatment
- The alternatives to having the treatment;
- What might happen if I do not have the assessment/treatment; and
- Any potential risks and/or side effects for the assessment and recommended treatment.

I understand and agree with the criteria above and as such agree to participate in an assessment and treatment program. My consent is voluntary for the entire course of assessment and treatment for my present condition, commencing on the date indicated below. I understand that I may ask questions at any time, and that my consent may be withdrawn in writing at any time, except for actions already taken.

Consent to Assessment	**Consent to Treatment**
____________________ Client Signature	____________________ Client Signature
____________________ Therapist Signature & Designation	____________________ Therapist Signature & Designation
____________________ Date	____________________ Date

…/2

CONSENT to the RELEASE of INFORMATION

I ___________________________________ give my informed consent to the Clinic to release information with respect to my care to the following:

1. **Insurer:** To disclose medical and/or other information with the relevant third party (indicate ICBC, WSBC, extended health insurance, etc): ____
   □ Yes □ No ______ Initials

2. **Medical Professional**(s): To disclose medical information to and obtain medical information from my Physician, Specialists or other treating therapists for the purpose(s) of assessing or providing treatment services.
   _________________________________ ______ □ Yes □ No ______ Initials
   _________________________________ _____ _ □ Yes □ No ______ Initials
   _________________________________ ______ □ Yes □ No ______ Initials

3. **Employer or their Representative**: To discuss return to work information with my Employer or their Representative (per the limitations of this discussion as reviewed with my physiotherapist)
   ____ □ Yes □ No ______ Initials

4. **Lawyer**: to disclose medical or other information to my Lawyer (if applicable)
   ____ □ Yes □ No ______ Initials

5. **Other** (explain) ____
   □ Yes □ No ______ Initials

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice and that revoking consent may have additional consequences such as withdrawal of treatment or the decline of a payment by an third party payer.

_________________________ ___________________________ ________________
Client Name/Parent (if under 18) Signature Date

GENERAL POLICIES

Massage Treatment

Your massage treatment includes assessment, reviewing the health history form with your therapist, massage, and self-care advice at the end of the treatment.

First Visit

Your RMT/AT will review your health history form with you and will ask you questions to ensure that you receive a treatment that meets your needs. You will be asked to update this form yearly or within 10 days for address changes and any health-related changes that your RMT should be aware of.

Illness

If you have a fever or a cough related to covid, flu or cold symptoms, please call and reschedule your appointment. Massage is contraindicated for fevers and can exacerbate flu-like symptoms. Please leave a message for your therapist if you need advice.

Cell Phones

We ask that you do not make or receive phone calls on portable devices while in the clinic.

LATENESS POLICY

Clients are responsible for the time they reserve for their appointment. If you are late for your appointment the treatment will still end at the designated time with no change in fee.

PHOTO/VIDEOS POLICY

During the assessment and treatment pictures or videos may be used to assess and treat your injury. At all times, you will be made aware if a photo or video is being taken and your consent must be verbally acknowledged. This will not be used for any circumstances other than medical or for the improvement of science should you consent and unless given permission, your identification (face, name, etc) will not be shared.

CANCELLATION POLICY

When you book an appointment with an RMT, you are booking that RMT's time. In order to accommodate all our clientele, we need 24 hours' notice of cancellation and/or rescheduling; less than that is inadequate time for us to offer your appointment time to others. If you are unable to make your appointment, we request that you call 24 hours in advance. If you do not call to cancel and/or reschedule before the 24-hour period, a cancellation fee will be charged.

Cancellation fees are ~60% of treatment fees, subject to HST, and subject to change with notice for the first offence. Any subsequent cancellations will require payment in full. The full cancellation fee is given to the RMT for their time lost. Please note that your RMT only receives payment if you pay the cancellation fee. For more information, please ask reception.

*****If you book within the 24-hour time frame, the policy is in effect immediately. *****

I have read, understood, and agree to both pages one and two of this policies document, including:

- ***Cancellation Policy*** **– I agree to pay the cancellation fee if I cancel or reschedule within the 24 hours preceding my appointment time. If the therapist has left their home, you will pay the full price.**
- ***Lateness Policy*** **– I agree to pay for the full time I reserved with the therapist even if the treatment length is decreased because I arrived late for my appointment.**

Signature: ____

Date (MMM/DD/YR): ____

Thank you for your consideration and cooperation.