handsON Clinic
Osteopathy and Physiotherapy

1547 Hurontario St., Mississauga

ON L5G 3H7 Canada

Confidential Patient Information

Last Name: ____________________ First name: ____________________ Date of Birth: ____________________

Address: ____________________ City/Province: ____________________ Postal Code: ____________________

Phone: ____________________ Alternate Phone: ____________________ Email: ____________________

Occupation: ____________________ Insurance Company: ____________________ Source of Referral: ____________________

Medical History

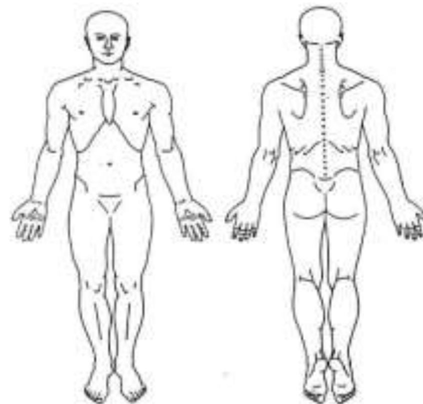
Chief Complaint: what brings you to the office? ____________________

Which of following apply to you?

☐ Heart disease ☐ Insomnia ☐ Nervousness
☐ Hernia ☐ Sciatica ☐ Varicose Veins
☐ Headache ☐ Epilepsy ☐ Stroke
☐ Cramps ☐ Cancer ☐ Urinary Disorder
☐ Fainting ☐ Prosthesis ☐ Constipation
☐ Hypertension ☐ Arthritis ☐ Dizziness
☐ Diabetes ☐ Scoliosis ☐ Atherosclerosis
☐ Ulcers ☐Vertigo ☐ Infection

Have you had surgery done?____________________
Nature of surgery:____________________
Date of Surgery: ____________________
(For Women)
Is there any possibility that you are pregnant?
☐ Yes ☐ No

Indicate where you feel discomfort.



Quality of Pain: ☐ Sharp ☐ Shooting ☐ Aching
☐ Numbness ☐ Swelling ☐ Stiffness ☐ Tingling ☐ Other

Informed Consent

I the undersigned, give my full and voluntary consent to osteopathic and massage therapy treatment by a qualified registered practitioner. I acknowledge that I understand the nature of the treatment, the expected benefits of the treatment, and the material risks and side effects of the treatment proposed. I also understand that alternative treatment is available. I further comprehend the likely consequences of not having the treatment. I remain free to withdraw my consent in writing at any time and the treatment shall cease at such time.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. 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 and understand that the therapist must be fully aware of my existing medical conditions. 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.

I understand that to provide me with Osteopathic, Massage Therapy, and Physiotherapy goods and services, HandsOn Osteopathy and Physiotherapy Clinic will collect some personal information about me (e.g. telephone number, address, insurance coverage). I understand the fee schedule, and that payment is due when services are rendered along with any other statements pertaining to pay schedules. I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my Osteopath Practitioner(s), Massage Therapist(s), and Physiotherapist(s) the nature and treatment in general (including spinal adjustment), the treatment options and recommendations for my condition and the contents of this Consent. I intend this consent to apply to all my present and future Osteopathic, Massage Therapy, and Physiotherapy.

As a Patient/Client, it is necessary to have a full assessment performed this is required for so that a relevant, safe, effective treatment plan can be set up for you. The assessment is part of the initial health history form must be completed and a re-assessment must take place each year to ensure all information is current. If there any changes to a health condition, patient is responsible to notify the clinic.
Payment can be made in cash, cheque, credit or debit and a receipt will be issued to you following treatment, and cheques returned (NSF) will be subject to a **service fee of $50**. Any charges for treatments and/or products are **non refundable**. I understand to notify the practitioner or reception of **inability to attend my scheduled appointment** 24 hours in advance. A **full amount** of your **appointment will be charged** for missed/late cancellation appointments.
I understand that my **late arrival will require that the session will end at the scheduled time.** This means that the scheduled session will be shorter. We have reserved this time for you and there are clients right after.
Inappropriate actions or language is cause for termination of treatment. We reserve the right to refuse service to anyone.
Patients/Clients under the age of 16 **must** have parent or legal guardian accompanying them.

By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me. As well as, additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment.

Patient's Name __________________________ Patient's Signature_____________________

Practitioner's Signature____________________ Date__________________________