handsON Clinic
Osteopathy and Physiotherapy

1547 Hurontario St., Mississauga
ON L5G 3H7 Canada

Intake Form

Please fill out these forms completely and to the best of your knowledge.

Full Name: _____

Address: _____ City/Province: _____

Postal Code: _____ Date of Birth: _____ Gender: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-Mail: _____ Occupation: _____

Insurance Company/Coverage: _____

Primary Physician: _____ Phone: _____

Full Address: _____

Have you ever received Osteopathy before? ☐ Yes ☐ No Massage Therapy?: ☐ Yes ☐ No

Other Healthcare Practitioners/Therapists that you are seeing:

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____

How did you hear about us? ☐ Doctor: _____ ☐ Other Practitioner:_____

☐ Website ☐ Signage ☐ Word of Mouth: _____ Other: _____

Overall, how is your general health? _____

This is a confidential record of your medical history and will be stored under lock and key, and will remain stored for 10 years after your last treatment. Patients underage will have their medical history stored for 10 years after they turn 18.

Information contained in it will not be released to any person unless you authorize to do so.

The health information requested on the following forms will assist us in treating you in the most efficient and safe way possible. If you have any questions about the requested information please feel free to ask. Your written permission is required to release any information, unless required by law.

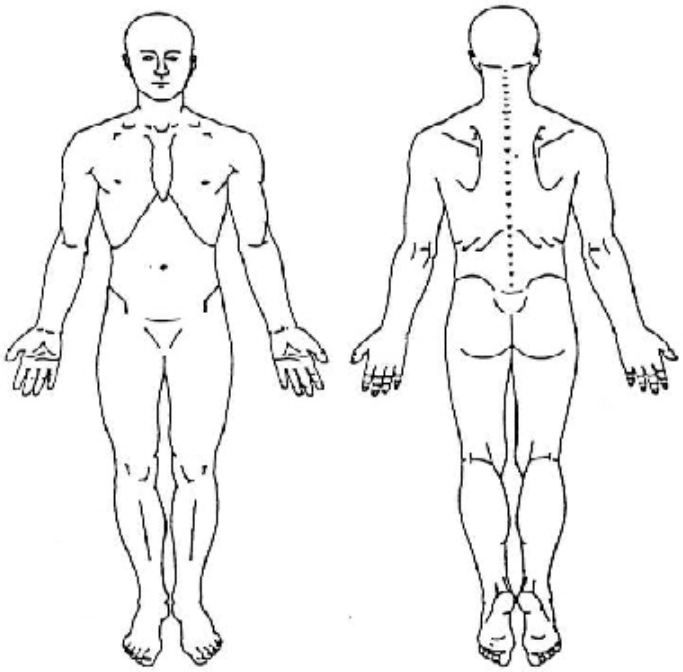
Health History

What is your main health concern/chief complaint? What brings you to our office?

_____

_____

Which of the following apply to you?



☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart Attack

☐ Stroke / CVA ☐ Chronic Congestive Heart Failure

☐ Pacemaker ☐ Phlebitis / Varicose Veins

☐ Heart Disease ☐ Family history of heart issues

☐ Chronic Cough ☐ Shortness of breath ☐ Bronchitis

☐ Asthma ☐ Emphysema

☐ Family history of respiratory difficulties

☐ Hepatitis ☐ HIV/AIDS ☐ Herpes ☐ TB

☐ Vision problems ☐ Vision loss ☐ History of headaches

☐ History of migraines ☐ Ear problems ☐ Hearing loss

☐ Skin conditions: _____

☐ Allergies/sensitivity: _____

Type of reaction: _____

☐ Diabetes ☐ Cancer ☐ Epilepsy ☐ Arthritis

☐ Arthritis in the family ☐ Hernia ☐ Menstrual Cramps

☐ Fainting ☐ Vertigo ☐ Dizziness ☐ Insomnia

☐ Sciatica ☐ Scoliosis ☐ Urinary Disorder

☐ Constipation ☐ Diarrhea ☐ Fibromyalgia ☐ Osteoporosis

☐ Anxiety ☐ Depression ☐ Ulcers: _____

Quality of pain: ☐ Sharp ☐ Shooting ☐ Aching

☐ Numbness ☐ Swelling ☐ Tingling ☐ Stiffness

☐ Dull ☐ Burning ☐ Cramping ☐ Stabbing

Other: _____

Is there any possibility that you are pregnant? ☐ Yes ☐ No

Any other medical conditions (atherosclerosis, haemophilia, mental illness etc.): _____

Do you have any internal pins, wires, artificial joints, or other implants?: _____

Do you have any gynaecological conditions?: _____

Please list **ANY** and **ALL** surgeries you have had (inc. date):

_____

_____

_____

Please list **ANY** and **ALL** injuries you have had (inc. date)

_____

_____

_____

Current Medications/Supplements/Vitamins:

_____

_____

_____

Reason for Taking Medication/Supplement/Vitamin:

_____

_____

_____

INFORMED CONSENT TO MANUAL TREATMENT

I understand that the Osteopathic Manual Practitioner (OMP) is providing osteopathic manual therapy within their scope of practice. I understand that the Registered Massage Therapist (RMT) is providing massage therapy within their scope of practice.

I understand that treatments include manual therapies where the OMP/RMT places his/her hands on my body. I understand that treatments include skin on skin contact between me and the OMP/RMT. If intra-oral work is required, disposable latex or vinyl gloves will be worn.

I understand that the OMP/RMT may ask me to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The techniques can be discontinued or modified to be comfortable for you.

I acknowledge that the OMP/RMT is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that I understand the nature of the treatment, expected outcome and that with any treatment there can be risks and side effects and those risks and side effects have been explained to me and I assume those risks and side effects. I understand that alternative treatment is available. I further comprehend the likely consequences of not having the assessment and treatment.

I acknowledge and understand that the OMP/RMT must be fully aware of all my existing medical conditions including any contraindications to treatment. I have completed my medical history form as provided to me by my OMP/RMT and have disclosed to the OMP/RMT all of those medical conditions affecting me including contraindications to treatment. I understand that it is my responsibility to keep the OMP/RMT updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I understand that my health history will need to be updated at least once a year. I understand that my health history information may be shared with other OMPs and RMTs practicing at the HandsOn Osteopathy and Physiotherapy Clinic in order to facilitate treatment.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy with my OMP/RMT. I acknowledge that I have had the opportunity to question the contents and my therapy.

CANCELLATION POLICY

Patients are required to provide **24 hour notice** for any cancellation. That time has been reserved for you and we appreciate having adequate time to fill the spot. The clinic reserves the right to charge the **full fee for missed/late cancellation appointments** with less than **24 hour notice**. **Thank you for respecting our time.**

CLINIC POLICY

Payment can be made in cash, cheque, credit or debit and a receipt will be issued to you following payment. Returned (NSF) cheques will be subject to a **$50 service fee**. Any charges for treatments and/or products are **non refundable**. Session time for late arrivals will not be extended, meaning a shorter session. **It is your responsibility to arrive on time to receive the full treatment time scheduled**. Inappropriate actions and/or language are 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.**

CONSENT TO ASSESSMENT AND TREATMENT

By signing this form here, I acknowledge the above and confirm my consent to assessment and treatment and intend this consent to cover the treatment discussed with me and such additional assessments and treatments as proposed to me by my **OMP** from time to time, to deal with my physical, emotional, and mental conditions and for which I have sought treatment. I understand that it is my right to withdraw consent for assessment/treatment at any time for any reason including during assessment/treatment.

DATE: _____ **Signature: _____**

By signing this form here, I acknowledge the above and confirm my consent to assessment and treatment and intend this consent to cover the treatment discussed with me and such additional assessments and treatments as proposed by my **RMT** from time to time to deal with my physical conditions for which I have sought treatment. I understand that it is my right to withdraw consent for assessment/treatment at any time for any reason including during assessment/treatment.

DATE: _____ **Signature: _____**

Assessment & Treatment Consent Form

Client Name: _____

As per the Standards of Practice set out by the College of Massage Therapists of Ontario and Protecting Patients Act, your RMT is required to obtain written consent for assessment and treatment of sensitive areas. The RMT will now be requesting consent for these areas of the body to be assessed and treated to ensure the guidelines are met and the safety of his clients is ensured. **Please read, and fill out accordingly.**

Written initials are an indication of my voluntary consent/permission that can be withdrawn at any time, including during treatment.

Date										
Area of Assessment	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**
Gluteals/Buttocks										
Chest wall (Ribs, Sternum Pectorals, Not Breast)										
Groin, Upper Inner Thigh										
Abdomen, Front of Pelvis										
Breast Tissue Only										
Therapist Initials										
Date										
Area of Treatment	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**	**Initials**
Gluteals/Buttocks										
Chest wall (Ribs, Sternum Pectorals, Not Breast)										
Groin, Upper Inner Thigh										
Abdomen, Front of Pelvis										
Breast Tissue Only										
Therapist Initials										