VELOCITY
Sports Medicine & Rehabilitation

Massage Patient Information and Health History

PATIENT INFORMATION (Please Show Health Card to Receptionist)				
☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	First Name	Middle Initial	Last Name	Marital Status: ☐ Sgl ☐ Mar
Birth Date (MM/DD/YR)		Age	Health Card Number (& Version Code)	
Street Address		City	Province	Postal Code
Home Telephone	Work Telephone	Cell Phone	Email Address	
Family Physician	Physician Telephone	Emergency Contact (Name/Relation/Tel#)		Occupation

Is this your first massage (including other clinics)?: Yes No

Primary Complaint: _____

Medications Reason for use

_____ _____
_____ _____
_____ _____

MEDICAL HISTORY

Cardiovascular
- ○ Hemophilia
- ○ Stroke
- ○ Heart Attack
- ○ High blood pressure
- ○ Low blood pressure
- ○ Chronic Congestive Heart Failure (CCHF)
- ○ Varicose veins
- ○ Dizziness
- ○ Chest pain
- ○ Phlebitis

Respiratory
- ○ Asthma
- ○ Chronic cough
- ○ Bronchitis
- ○ Difficulty breathing
- ○ Emphysema

Neurological
- ○ Multiple sclerosis
- ○ Loss of sensation
- ○ Neuritis
- ○ Migraine
- ○ Sciatica
- ○ Disc hernia

Muscles/Joints/Skin
- ○ Arthritis
- ○ Osteoporosis
- ○ Allergies
- ○ Infectious skin condition
- ○ Anaphylactic shock

Gastrointestinal
- ○ Abdominal discomfort
- ○ Constipation
- ○ Dysentery

Other
- ○ Cancer
- ○ Hearing loss
- ○ Vision loss
- ○ HIV/AIDS
- ○ Hepatitis
- ○ Tuberculosis
- ○ Endometriosis
- ○ Dysmenorrhea
- ○ Pelvic inflammatory disease
- ○ Pregnancy
- ○ Prostate
- ○ Pacemaker

Life Style
- ○ Exercise
- ○ Alcohol
- ○ Drugs
- ○ Caffeine
- ○ Smoking

Problem Areas
- ○ Shoulder
- ○ Elbow
- ○ Wrist
- ○ Ankle
- ○ Spine
- ○ Muscle soreness
- ○ Hip
- ○ Knee
- ○ Hand
- ○ Foot
- ○ Pins, wires plates
- ○ Other: _____

Therapies
- ○ Chiropractic
- ○ Physiotherapy
- ○ Other: _____

PAST SURGERIES AND INJURIES

Surgery/Injury	Date

ADDITIONAL COMMENTS

_____
_____
_____
_____
_____

I hereby accept and verify that the information given on this form is true and accurately reflects my past and present health status.

_____ ----------

Signature **Date**

Informed Consent To Massage Therapy Treatment

Massage therapist who use manual therapy techniques are required to advise patients that there are or may be some risk associated with such therapy. In particular you should note:

- While rare, some patients have experienced muscle and ligament tenderness following massage therapy.

Massage therapy has been the subject of government and multi-disciplinary studies conducted over many years, and have been demonstrated to be highly effective treatment for muscle strains, headaches, and other similar symptoms. Massage therapy contributes to you overall well being. The risk of injury or complications from massage therapy is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed or have had the opportunity to discuss, with my massage therapist the nature and purpose of treatment in general and my treatment in particular as well as the content of this consent.

I consent to massage therapy treatment offered or recommended to me by my massage therapist. I intend this consent to apply to all my present and future massage care.

_____ Date:_____ **_____ Date: _____**

Patient Signature (Legal Guardian) **Witness Signature**

Fee Schedule

Initial Assessment- Chiropractic/Physiotherapy-**$140;** Follow-up-Chiropractic/Physiotherapy-**$75;** New Complaint- Chiropractic/Physiotherapy:**$110**; Massage Therapy- 30min; **$62.15**, 45 min; **$84.75**, 60 min; **$96.05**

Initials: ____

All additional fees will be provided prior to service. Service:_____ Fee: _____

24hr-Cancellation Policy: The full cost of the appointment will be applied to your account if less than 24 hours notice is given for cancelled appointments.

Payment is due at the time services are rendered. For your convenience, we accept cash, Visa, and Master Card. This policy applies to all of our patients.

If you have not made payment in full or made full financial arrangements with our office, your account will be reviewed for collection. Patients having health care insurance should remember that professional services provided are the patient's responsibility, not the facility or the insurance company. **If payment is not made on a bill from our office within forty-five (45) days after the date of such bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be thirty percent (30%) per annum.**

Our office does **not** file insurance claims for you. However, we would be happy to provide you with the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment and for collecting from the other parent or attorneys.

SPECIAL SUPPLIES

Custom made knee braces or other specialty orthotics and braces will not be ordered for a patient until the patient has paid at least 50% of the item cost. We do realize that specialty braces are an expensive part of your treatment and we do make every attempt to control these costs. Our staff is available to assist patients with insurance benefit verification for such items.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid any confusion.

We require a credit card on file to protect against delinquent accounts. Accounts must be cleared within 30-days of service if they are not your credit card will be debited in that amount.

PAYMENT OPTION: For convenience purposes, should you like to have your account debited after each service please circle **YES**

Thank you for allowing us to be part of your health care. We want your experience with Velocity Sports Medicine & Rehabilitation to be a pleasant one and we hope this information will help to make it so. I have read Velocity Sports Medicine & Rehabilitation financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy.

I HEREBY I AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT Velocity Sports Medicine & Rehabilitation.

Patient signature: **Date:**

Velocity Sports Medicine & Rehabilitation- 167 Lakeshore Road West, Mississauga, ON L5H 1G3
905.891.1999 F. 905.891.1905

VELOCITY
Sports Medicine & Rehabilitation

167 Lakeshore Road West
Mississauga, ONT. L5H 1G3
905-891-1999

Treatment Plan for: _____ **Date:** _____ **Therapist:** _____

Appointment Time: _____ am/pm **Duration:** _____ minutes **Fee: $** _____ ☐CTT ☐CTA

Date of Injury/Accident: _____ **Current Medications/Therapies:** _____

Subjective: ☐Relax ☐Tx ☐Maintenance **Symptoms:** Location/Intensity/Frequency/ Onset /Duration/ Sight/Spread

_____

_____

_____

_____

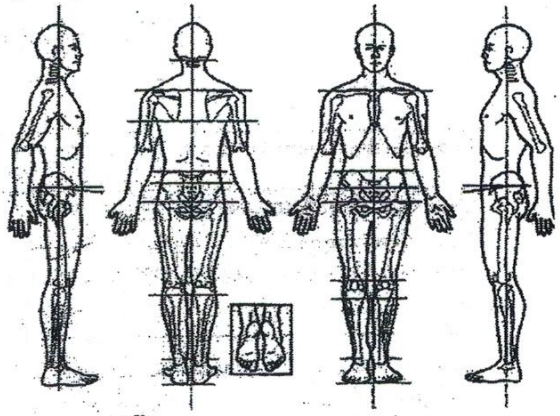
_____

Limitations (Relieving) Daily Activities: _____

_____

_____

Objective, Assessments & Results:



Client's Goal:

Treatment Goal (type/focus):

Treatment Plan Discussed with Client: Yes / No **Received Informed Consent For Treatment Plan: Yes / No**

Areas Treated: ☐back ☐neck ☐shoulder ☐chest ☐head ☐face ☐arms L/R ☐hands ☐legs L/R ☐hip area ☐feet ☐abs ☐breast ☐FB

Techniques Used: light/mod/deep P ☐Swedish ☐MFR ☐TrP ☐joint mob ☐hydro ☐GTO ☐M stripping ☐rhythmic ☐CST ☐LD

☐frictions ☐breast massage ☐intra oral ☐stretch: _____

_____

_____

Client Feedback: ↓ ↑ % of Δ ____ ☐looser ☐more relaxed ☐light headed ☐compliant to Remex _____

_____

_____

Frequency/Duration/Self Care: Txs: ____ xs per week/biweekly/month for ____ mins for ____ weeks/month/ongoing ☐PRN

☐ESB ☐Hot shower ☐RICE ☐Postural Techniques ☐Breathing Techniques ☐Stretches/Strengthening: _____

_____

Referral: ☐MD ☐DC ☐DOMP ☐PT ☐DAC ☐CST ☐RMT ☐ND ☐OTHER: _____

Anticipated Progression of Responses: **Reassessment schedule:** **Contraindications/Risks:**