



665 Earl Armstrong Road, Unit 7
Ottawa, ON; K1V 2G2
613-425-JRJR (5757)
613-425-8699 Phone
613-425-8633 Fax
www.jointreaction.ca

Patient Name: _____

Date: _____

Telephone: (H) _____

(W) _____

(C) _____

Email address (required): _____

Address: _____

Postal Code: _____

Credit Card (Optional): _____

Visa MasterCard Expiry Date: _____

Verification Code: _____

In Case of Emergency: Name: _____

Phone: _____

Relationship: _____

How did you hear about us?

Doctor Internet Referred by another client Mail-out

Signage (Please circle one: On building, Mall Pylon, Roadside, Billboard)

Other (Please specify) _____

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____
 Address: _____ Postal Code: _____
 Occupation: _____ Date of Birth: _____

Have you received Massage Therapy before? Yes No Have you received Physiotherapy before? Yes No
 Have you ever received Chiropractic before? Yes No
 Did a health care practitioner refer you for therapy? Yes No
 If yes, please provide their name and address. _____

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> chronic congestive heart failure <input type="checkbox"/> heart attack <input type="checkbox"/> phlebitis / varicose veins <input type="checkbox"/> stroke/CVA <input type="checkbox"/> pacemaker or similar device <input type="checkbox"/> heart disease</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema</p> <p>Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Infections</u></p> <p><input type="checkbox"/> hepatitis <input type="checkbox"/> skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> herpes</p> <p><u>Other Conditions</u></p> <p><input type="checkbox"/> loss of sensation, where? _____ <input type="checkbox"/> diabetes, onset: _____ <input type="checkbox"/> allergies /hypersensitivity to what? _____ _____ type of reaction: _____ <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer, where? <input type="checkbox"/> skin conditions, what? <input type="checkbox"/> arthritis</p> <p>Is there a family history of arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have seasonal allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Head/Neck</u></p> <p><input type="checkbox"/> history of headaches <input type="checkbox"/> history of migraines <input type="checkbox"/> vision problems <input type="checkbox"/> vision loss <input type="checkbox"/> ear problems <input type="checkbox"/> hearing loss</p> <p><u>Women</u></p> <p><input type="checkbox"/> pregnant due: _____ <input type="checkbox"/> gynecological conditions, what? _____</p> <p>Overall, how is your general health? _____</p> <p>Primary Care Physician: _____ Address: _____ _____ _____ _____</p>
---	---	---

<p>Current Medications: _____ _____ Condition it treats: _____ _____</p> <p>Are you currently receiving treatment from another health care professional? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, for what? _____</p> <p>Surgery - date: _____ nature: _____ Injury - date: _____ nature: _____</p>	<p>Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) <input type="checkbox"/> No <input type="checkbox"/> Yes What? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes What? _____ Where? _____</p> <p>What is the reason you are seeking therapy? Please include the location of any tissue or joint discomfort. _____ _____ _____</p>
--	---

Notes:

Date of initial Health History: _____ Update 1: _____ Update 2: _____



665 Earl Armstrong Road, Unit 7
Ottawa, ON; K1V 2G2
613-425-JRJR (5757)
613-425-8699 Phone
613-425-8633 Fax
www.jointreaction.ca

Therapeutic Checklist

This agreement is to ensure that there is a clear understanding between the therapist and the client of each other's goals, both short and long-term, and what is expected and realistic for each. The quality and effectiveness of your treatments and treatment plan will be enhanced by the feedback you give your therapist. The more specific the feedback the more targeted your treatment can be.

1. How important is it for you to get better? **Scale of 1-10** _____
2. How motivated are you to get better? **Scale of 1-10** _____
3. Are you self-disciplined and able to stick to a Treatment Program including daily exercises?
Yes No Maybe
4. What are your time expectations for getting better? **Today, Days, 1 month, 2 months, 3 months**
5. How many times per week are you able to commit for treatment? **1/week, 2/week, 3/week**

Long term goal(s):

Short term goal(s):

- 1) _____
- 2) _____
- 3) _____

Physiotherapy and Massage Therapy have a cumulative effect on the body; therefore, by following your therapist's recommended frequency for both treatments and home exercises, you will be able to achieve the best results. Your therapist(s) will advise you on a schedule to realize your maximum results in the least amount of time. The less frequent you are able to attend treatment and/or perform the recommended exercises, the slower your progress will be. Consistency is paramount in order to achieve maximum results, with regards to home exercise program adherence, as well as attending one's specified therapy sessions.

Name (Print): _____ Date: _____

Signature: _____



7-665 Earl Armstrong Road
 Ottawa, ON; K1V 2G2
 613-425-JRJR(5757) OR
 613-425-8699 Phone
 613-425-8633 Fax
 www.jointreaction.ca

PHYSIOTHERAPY PRICING

INITIAL ASSESSMENT AND TREATMENT	\$115
PHYSIOTHERAPY TREATMENT ONE AREA	\$90
PHYSIOTHERAPY TREATMENT 2 AREAS	\$105
PHYSIOTHERAPY TREATMENT 3 AREAS	\$115

REGISTERED MASSAGE THERAPY PRICING (HST INCL.)

INITIAL ASSESSMENT AND TREATMENT (1HR)	\$105
SUBSEQUENT TREATMENT (1HR)	\$105
SUBSEQUENT TREATMENT (1/2 HR)	\$63
SUBSEQUENT TREATMENT (90 MIN)	\$168

CHIROPRACTIC PRICING

INITIAL ASSESSMENT AND TREATMENT	\$95
SUBSEQUENT TREATMENT	\$55

CANCELLATION POLICY

PLEASE PROVIDE NO LESS THAN 24 HOURS NOTICE TO CANCEL ANY APPOINTMENTS TO AVOID BEING SUBJECT TO A CANCELLATION FEE OF \$45, WHILE A NO SHOW WILL BE BILLED THE FULL FEE. THESE FEES WILL BE PAID BY THE CLIENT AND ARE NOT COVERED BY YOUR INSURANCE COMPANY OR WSIB.

IF YOU DECIDE TO MOVE YOUR APPOINTMENT TO ANOTHER DAY IN THE SAME WEEK, LESS THAN 24HRS PRIOR TO YOUR APPOINTMENT, YOU MUST ATTEND THE SAME AMOUNT OF APPOINTMENTS SCHEDULED FOR THAT WEEK. OTHERWISE YOU ARE SUBJECTED TO THE CANCELLATION FEE. FAILURE TO RESPOND TO NOTIFICATION OF THESE FEES WILL RESULT IN THE ACCOUNT BEING SENT TO A COLLECTION AGENCY. FAILURE TO PAY THE FEES WILL RESULT IN THE ACCOUNT BEING SENT TO A COLLECTION AGENCY.

I have read and agree to the terms of the cancellation policy.

Initials: _____

CONFIDENTIALITY

All records are confidential. Release of medical information to a third party (i.e. work lawyer, insurance company) will be subject to your approval. Progress reports and Discharge reports will be forwarded to a family/referring physician. All client information sent is passed through our Health Information Custodian (HIC) Scott Mooney. Any questions regarding privacy may be directed to scott@jointreaction.ca.

CONSENT TO ABOVE POLICIES AND CONDITIONS

I, the undersigned, have read and understand the above stated and consent to the terms of the cancellation policy. I give permission to Joint Reaction Health Center to assess, treat and educate me with a therapeutic program that is best suited for my condition. Risks cannot be completely eliminated but all precautions will be made to minimize them, including but not limited to COVID-19.

Name: _____
 Please Print

Date: _____

Signature: _____

Parent/Guardian: _____
 (Child is Patient)