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 (Optional):_____

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:

Cardiovascular
□ high blood pressure
□ low blood pressure
□ chronic congestive heart failure
□ heart attack
□ phlebitis / varicose veins
□ stroke/CVA
□ pacemaker or similar device
□ heart disease

Is there a family history of any of the above? □ Yes □ No

Respiratory
□ chronic cough
□ shortness of breath
□ bronchitis
□ asthma
□ emphysema

Is there a family history of any of the above? □ Yes □ No

Infections
□ hepatitis
□ skin conditions
□ TB
□ HIV
□ herpes

Other Conditions
□ loss of sensation, where?
_____
□ diabetes, onset:_____
□ allergies /hypersensitivity to what?_____
_____
type of reaction:_____
□ epilepsy
□ cancer, where?
□ skin conditions, what?
□ arthritis

Is there a family history of arthritis? □ Yes □ No

Head/Neck
□ history of headaches
□ history of migraines
□ vision problems
□ vision loss
□ ear problems
□ hearing loss

Women

□ pregnant due:_____
□ gynecological conditions, what? _____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____
_____
_____

Current Medications:_____
_____
Condition it treats:_____

Are you currently receiving treatment from another health care professional? □ No □ Yes
If yes, for what?_____

Surgery - date:_____
nature:_____
Injury – date:_____
nature:_____

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) □ No □ Yes What?_____

Do you have any internal pins, wires, artificial joints or special equipment? □ No □ Yes
What?_____
Where?_____
What is the reason you are seeking therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

Notes:

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

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Health Center
Physiotherapy • Massage
Foot Care

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PHYSIOTHERAPY PRICING

INITIAL ASSESSMENT AND TREATMENT	$95
PHYSIOTHERAPY TREATMENT ONE AREA	$75
PHYSIOTHERAPY TREATMENT 2 AREAS	$95
PHYSIOTHERAPY TREATMENT 3 AREAS	$105

REGISTERED MASSAGE THERAPY PRICING (HST INCL.)

INITIAL ASSESSMENT AND TREATMENT (1HR)	$95
SUBSEQUENT TREATMENT (1HR)	$95
SUBSEQUENT TREATMENT (1/2 HR)	$56.50
SUBSEQUENT TREATMENT (90 MIN)	$151.50

CANCELLATION POLICY

PLEASE PROVIDE NO LESS THAN **24 HOURS NOTICE** *TO CANCEL ANY APPOINTMENTS TO AVOID BEING SUBJECT TO A* **CANCELLATION FEE** *OF* **$40**, *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 CANCELATION 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.

Name: _____ Date: _____
Please Print

Signature: _____ Parent/Guardian: _____
(Child is Patient)

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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:_____