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:

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

Do you have seasonal allergies? □ Yes □ No

Head /N ec k
- □ 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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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:_____________________________________

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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	$105
SUBSEQUENT TREATMENT	$60

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 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. Risks cannot be completely eliminated but all precautions will be made to minimize them, including but not limited to COVID-19.

Name: ________________________ Date: ____________________
Please Print

Signature: _______________________ Parent/Guardian: __________________________
(Child is Patient)

September 1, 2020