

Back to Health Wellness Centre
Dr. Barbara A. Rodwin
240 Catherine St. Suite 100
Ottawa, Ont.
K2G 2G8
(613) 237-3306 Office
(613) 237-3100 fax
reception@back2health4you.com

Below you will find the New Patient paperwork you will need for your upcoming massage appointment at the Back to Health Wellness Centre.

Please complete and fax it back to us prior to your appointment time or email to reception@back2health4you.com.

Our fax number is (613) 237-3100.

Please note, there is one row of visitor parking and it is the first row as you enter the parking lot. If it is full, please come into our clinic and pick up a parking pass that will allow you to park in any vacant spot.

Thank you very much, and we'll see you for your appointment!

Back to Health Wellness Centre
Confidential Health History

240 Catherine St., Ste 100
Ottawa, Ontario
Ph: 613- 237-3306 Fax: 613-237-3100

Name: _____
Address: _____
City: _____ Prov: _____
Postal Code: _____
Phone(H): _____ (W): _____
E-Mail: _____
Current Date: _____

Referred By: _____
Family Physician: _____
Address: _____
Phone: _____
Emergency Contact: _____
Phone: _____

Female Male Date of Birth: _____
Occupation: _____
What is your general health status? _____
What is your dominant hand?
 Left Right
What is your primary sleeping position?
 Side Back Front
Do you smoke? No Yes
If yes, how much per day: _____
Are you currently taking **ANY** medication?
 No Yes
Name medication and condition
including **supplements**:

Are you, or are you possibly pregnant?
 No Yes
Expected due date: _____
Do you exercise regularly? No Yes
Frequency: ___x/week
What are your recreational activities:

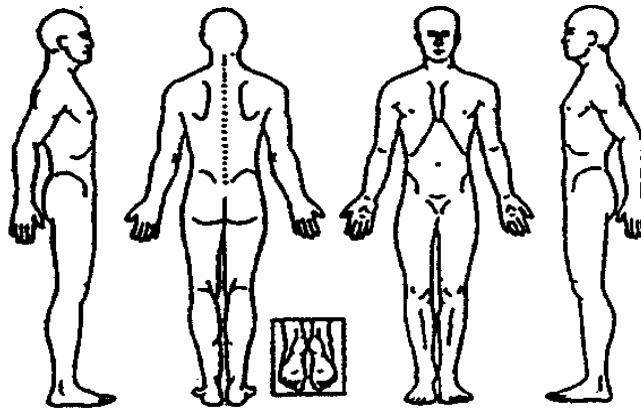
Do you have any internal pins, wires, artificial
joints or other special equipment (such
as a pacemaker or hearing aid)?
 No Yes
If yes, please explain:

Have you ever seen a Massage Therapist? _____
If yes, what is their name? _____
When was your last
treatment? _____

Have you ever been in a motor vehicle accident, sustained an athletic injury or other trauma? No
 Yes
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Have you ever been hospitalized? No Yes Have you ever had surgery? No Yes
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

What is the purpose of your visit: _____
What started this condition: _____
When did this condition begin: _____
What aggravates this condition: _____
What relieves this condition: _____
Have you received treatment from other healthcare providers for this condition? No Yes
If yes, who are they and what type of healthcare provider are they:



Please circle current symptomatic areas in your body on the diagrams above.

Have you been diagnosed with, or have you ever experienced any of the following?

If Yes, please mark with an "X" on the line provided.

Circulatory/Respiratory

- ___ Chronic congestive heart failure
- ___ Heart disease
- ___ Other heart condition
- ___ High blood pressure
- ___ Low blood pressure
- ___ Varicose veins
- ___ Phlebitis
- ___ Deep vein thrombosis
- ___ Raynaud's disease/phenomenon
- ___ Buerger's disease
- ___ Chronic cough
- ___ Bronchitis
- ___ Asthma
- ___ Emphysema
- ___ Shortness of breath

Musculoskeletal

- ___ Scoliosis
- ___ Bone or joint disease
- ___ Arthritis
- ___ Joint instability
- ___ Tendinitis
- ___ Fractured bones
- ___ Jaw pain (TMJ)
- ___ Whiplash

Skin

- ___ Sensitivities to oils, lotions, detergents
- ___ Other allergies or hypersensitivities
- ___ Irritated skin conditions
- ___ Contagious conditions
- ___ Frostbite
- ___ Lack of sensation

General

- ___ Cancer/Tumors
- ___ Undiagnosed lump
- ___ Diabetes
- ___ Kidney problems
- ___ Liver problems
- ___ Drug/Alcohol addiction or withdrawal
- ___ Infectious conditions (hepatitis, HIV, etc.)
- ___ Eating disorder
- ___ Recent abortion or vaginal birth
- ___ Loss of vision or hearing

Nervous system

- ___ Epilepsy
- ___ Multiple sclerosis
- ___ Cerebral palsy
- ___ Parkinson's
- ___ Nerve lesion
- ___ Sciatica
- ___ Carpal tunnel syndrome

Have you ever suffered from:

- Heart Attack No Yes
Date: _____
- Stroke No Yes
Date: _____

Please list any other condition not listed & provide details as necessary

I, _____ hereby declare that all of the above information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment.

Signature of Client: _____

Date: _____

Signature of Parent/Guardian (if applicable): _____

Date: _____

Please inform front desk immediately if there are **changes to your contact information.**

MESSAGE RATES

TIME	MESSAGE	MESSAGE & ART	ART
15	\$25	\$35	\$45
30	\$47	\$57	\$65
45	\$65	\$75	\$85
60	\$80	\$90	\$105
75	\$100	\$115	\$130
90	\$115	\$140	\$155

CANCELLATION POLICY

Due to the length of a massage treatment and the demand by the public for Massage Therapy and Active Release Technique (ART), we ask for at least 24 hours notice to cancel an appointment. Time is important to all of us. If you can't make it to an appointment, it is quite likely someone else would gladly take your slot.

You **will** be charged for a missed appointment if you do not show up for an appointment.

If less than 24 hours notice is given, *we reserve the right to charge you the fee of the appointment that you originally scheduled.*

Please be aware that **private health care insurance plans do not cover the fee for missed appointments.**

Thank you for your understanding.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

CONSENT TO TREATMENT

I, _____ hereby declare that all information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment.

I have given consent to my Massage Therapist to speak to any of my other medical practitioners (if necessary), to clarify any information divulged on the Case History Form, during assessment, or during treatment.

A treatment plan has been explained to me in detail by the therapist. I have also been informed of expected benefits to the treatment, possible risks and side effects, and possible consequences of not receiving this treatment.

I have been informed that I may stop or alter my treatment at any time.

I understand and agree with the fees for massage therapy and the consequences of improperly cancelled appointments.

The therapist has answered any questions I may have had to my satisfaction. Therefore, I give my consent to begin the proposed treatment.

Signature of Client: _____

Date: _____

Signature of Parent/Guardian (if applicable): _____

Date: _____

Signature of Massage Therapist: _____

Please initial to acknowledge you have read and/or taken possession of the Fee Schedule and Cancellation Policy. _____

Your privacy is very important to us. If you would like to review a copy of our privacy policy, please ask at reception.