Binbrook Chiropractic & Physiotherapy 3065 Highway 56 Binbrook, ON L0R1C0

HEALTH HISTORY FORM

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us now. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Preferred Name (if any): _____

Address: _____ Today's Date: _____

City: _____ Postal Code: _____

Telephone Number (Home): _____ (Cell): _____

Emergency Contact (Name and Phone Number): _____

E-mail Address: _____

Date of Birth: _____/_____/_____ Gender: M / F Occupation: _____
Month Day Year

Primary Care Physician: _____ Address: _____

Previous Chiro / Physio / Massage Care:_____ Last seen:_____

For what condition:_____ Results:_____

MVA or WSIB Claim number: _____

Health History: please indicate conditions you are experiencing or have experienced.

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ CCHF
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart palpations
- ☐ Heart murmur
- ☐ Aneurism
- ☐ Angina
- ☐ Blood Clots
- ☐ Raynaud's Disease
- ☐ Phlebitis/Varicose Veins
- ☐ Pacemaker/Similar Device
- ☐ Stroke/CVA
- ☐ Other _____

Blood
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Hepatitis A B C

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sinus Congestion
- ☐ other _____

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's/Colitis
- ☐ Hernia
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Urination Problems
- ☐ Poor Appetite
- ☐ Excessive Thirst

Skin
- ☐ Allergies:
- ☐ Hypersensitivity
- ☐ Bruises Easily
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot
- ☐ Herpes
- ☐ Warts
- ☐ Skin Conditions:

Family History
- ☐ arthritis
- ☐ cancer
- ☐ diabetes
- ☐ heart disease/stroke

Cigarette/Tobacco Consumption
- ☐ yes – amount _____/day
- ☐ no

Other Conditions
- ☐ diabetes: onset _____
- ☐ HIV/AIDS
- ☐ Cancer
  Type?
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Thyroid Disorders
- ☐ Lupus
- ☐ arthritis
- ☐ migraines &/or headaches
- ☐ Loss of Sensation
  Where?
- ☐ Insomnia/Fatigue
- ☐ Fainting/Dizziness
- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Alcohol/Drug Problem

Women
- ☐ pregnant: - due: _____
- ☐ Infertility
- ☐ Menstrual Concerns/Pain
- ☐ Menopausal Concerns
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ Vaginal Pain/Infection

Head/Neck
- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Hearing Problems
- ☐ Hearing Loss
- ☐ Vision Problems
- ☐ Vision Loss

Soft Tissue/Joint Discomfort
- ☐ Neck
- ☐ Muscle Strain
- ☐ Ligament Sprain
- ☐ Spasms/Cramps
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Arthritis OA RA
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Degenerative Disc
- ☐ Joint or Bone Disease
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture
- ☐ Low Back
- ☐ Mid Back
- ☐ Upper Back
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ other _____

Rate your General Health
- ☐ above average
- ☐ average
- ☐ below average

Are you currently taking any medications? _____

What is your **Current complaint?** _____

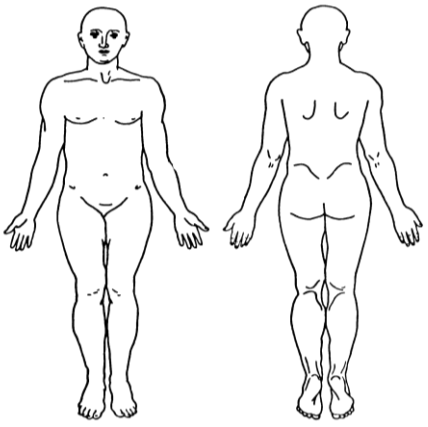
Has this condition occurred before? Yes/No

When did this condition begin? _____

Is the condition: ☐ Job-related ☐ Auto-related
☐ Fall ☐ Home Injury ☐ Other: _____

Date of Accident: _____

What happened? _____



Please mark on the diagram the area of your discomfort and any radiation of pain.

Circle the grade to indicate the severity of your pain:

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _____and approximately when? _____

Surgeries/Major Injuries (Nature/Date): _____

Presence of internal pins, wires, artificial joints, special equipment, etc._____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Dow ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Intermittent ☐ Constant

Does the pain radiate anywhere? ☐ No ☐Arm (L or R) ☐Leg (L or R) ☐Other: _____

When does it hurt? ☐Morning ☐ Evening ☐wakes me up at night ☐ Other: _____

Please describe how it feels when this problem is at its worse: _____

How did you hear about Binbrook Chiropractic and Physiotherapy? ☐ Referral from Doctor ☐ Friend/Patient
☐ Sign ☐ Flyer/Advertisement ☐ Other: _____

Caution: Use of oils may cause staining of apparel. Binbrook Chiropractic & Physiotherapy is not responsible for any apparel that may be stained during treatments.

Initial when read: _____

PRIVACY POLICY
PATIENT DISCLOSURE FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality care. We understand the importance of protecting your personal information, and are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Dr. Harnek S. Gill acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what your office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards or our regulatory body, or Ontario, and the law

Do not hesitate to discuss our policies with Dr. Harnek Gill or any member of our office staff.

Please be assured that every staff person in our office is committed to ensure that you receive the best quality care.

PRIVACY POLICY

How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care;
- To identify and to ensure continuous high-quality service;
- To assess your health needs;
- To provide health care;
- To advise your treatment options;
- To enable us to contact you;
- To establish and maintain communication with you;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up treatment and care;
- For teaching and demonstrating purposes on an anonymous basis;
- To complete and submit claims for third party adjudication and payment;
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act;

- To prepare materials for the Health Profession Appeal and Review Board (HPARB);
- To invoice for goods and services;
- To process credit card payments;
- To comply generally with the law;

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information; we will seek your approval in advance.
Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of fulfilling its mandate under the RHPA, and for the defense of a legal issue.
Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request made, we will forward the information directly to you for review, and for your specific consent.
When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.
You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and that process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.
I agree that Binbrook Chiropractic & Physiotherapy can collect, use and disclose personal information about me as set out above.

_____ _____
Signature Print Name

_____
Date

INFORMED CONSENT (Registered Massage Therapy)

I hereby request and consent to the performance of soft tissue manipulation and other massage techniques including hydrotherapy, trigger point release and joint mobilization.

I have been informed of any side effects involved in soft tissue therapy, including but not limited to rare allergic reaction to massage lotions and oils, bruising, light headedness or dizziness and tenderness. I will also be made aware of how this treatment will be performed for my condition. I understand these results may not be guaranteed.

I understand that I will be draped at all times and only the areas being treated will be undraped and that coverings will be secure to ensure my comfort.

I have given complete medical information, including any contagious or infectious diseases, and will inform my therapist of any changes in my health. I further acknowledge that the Registered Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. **Please initial_____**

I have read the above consent. I have also had an opportunity to discuss the techniques and purpose in my treatment with the Registered Massage Therapist listed below and to ask questions about its content. By signing I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. I acknowledge that I am required to advise the massage therapist if I am uncomfortable with any part of the treatment and that I may withdraw my consent at any time and treatment will be stopped. **Please initial_____**

I acknowledge that I am required to provide 24 hours notice to change, cancel and/or reschedule my massage therapy appointment. This will allow sufficient time to offer my scheduled appointment time to another client. I also acknowledge that **I will be charged full price for any cancelled appointments where appropriate notice is not given. Please initial_____**

_____ _____
Print Client Name Signature of client or substitute decision maker

_____ _____
Registered Massage Therapist Signature Date

_____ _____
Print Client Name Signature of client or substitute decision maker

_____ _____
Registered Massage Therapist Signature Date

_____ _____
Print Client Name Signature of client or substitute decision maker

_____ _____
Registered Massage Therapist Signature Date

Cancellation Policy
Binbrook Chiropractic & Physiotherapy

Your appointments and well-being are very important to us. We understand that sometimes, unexpected delays can occur, making schedule adjustments necessary. If you need to cancel your appointment, we respectfully require at a **minimum 24 hour notice**.

Our Policy:

● Any cancellation or reschedule made less than 24 hours prior will result in a cancellation fee. **The amount of the fee will be equal to 100% of the reserved services.**

● If you are more than15 minutes late for your service, we may not be able to accommodate you. In this case, the same cancellation fee will apply.

● We require a credit card to hold your appointment. Cancellation fees will be charged to your card on file.

● Insurance cannot be billed for missed appointments.

● We will do our best to contact individuals to provide courtesy reminders, but they are not guaranteed, or to be relied upon.

● In the event of a true, unavoidable emergency, all or part of your cancellation fee may be applied to future services.

I hereby authorize Binbrook Chiropractic & Physiotherapy to charge my credit card in accordance with this cancellation policy.

Name on Card: _____

Credit Card Number: _____

Expiry Date: _____ CVV:_____

Client Signature: _____

Date: _____