SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms.
http://www.sourcecentre.ca/about/more/terms-service/

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y ❍ N ❍

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature _____

Client Name _____ Date_____

Signature of parent or Guardian (for anyone under the age of 18):

Signature _____

Guardian/Parent Name _____ Date_____

Ceinwen Gobert RMT

HEALTH HISTORY

An accurate health history is important to ensure that it is safe for you to receive massage therapy. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.
24 hour cancellation notice is required otherwise a missed appointment fee will be charged.

Legal Name: _____ Tel. Res.: _____ Tel. Bus.: _____

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Email: _____ Would you like to receive our Source Centre Email Newsletter? ☐ Yes ☐ No

Date of Birth: ___/___/___ (mm dd yy) Occupation: _____ Male: ❑ Female: ❑ 1st Massage Therapy Treatment? ❑ Yes ❑ No

Primary Health Care Physician: _____ Address: _____ Tel.: _____

Primary Complaint: _____ Source of Referral: _____

General Health Status: _____

Please indicate conditions you are or have experienced with a check mark: ☑

Soft Tissue/Joints
(specify its nature i.e. pain, stiffness, numbness etc.)

- ❑ neck _____
- ❑ shoulder _____
- ❑ upper back _____
- ❑ mid back _____
- ❑ low back _____
- ❑ arms _____
- ❑ legs _____
- ❑ knees _____
- ❑ hip _____
- ❑ other: _____

Headaches

- ❑ tension ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ head trauma - date: _____
- ❑ other: _____

GI tract conditions

- ❑ IBS ❑ Crohn's
- ❑ constipation
- ❑ other: _____

Accident/Injury

- ❑ car accident work related? ❑ Yes ❑ No
- ❑ date: _____
- ❑ symptoms: _____

_____

_____

- ❑ Physical limitations: _____

_____

Surgery

- ❑ type: _____
- ❑ date: _____
- ❑ symptoms: _____

_____

Respiratory

- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma - triggers: _____ _____
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems

Cardiovascular

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack - date: _____
- ❑ phlebitis
- ❑ stroke/CVA - date: _____
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure

Infectious Disease

- ❑ hepatitis
- ❑ infectious skin conditions
- ❑ tuberculosis
- ❑ HIV
- ❑ other: _____

Women

- ❑ pregnant/due date: _____
- ❑ previous labour complications:

_____

Current medication & conditions

_____

_____

_____

Skin

- ❑ skin condition
  specify: _____
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ loss of sensation

Other Conditions

- ❑ neurological condition: _____
- ❑ epilepsy - triggers: _____ _____
- ❑ diabetes/onset: _____
- ❑ allergies: _____
  anaphylaxis? ❑ Yes ❑ No
  skin irritation? ❑ Yes ❑ No
- ❑ cancer
- ❑ arthritis - where? _____
  type? ❑ RA ❑ OA other: _____
  Family History? ❑ Yes ❑ No
- ❑ vision loss
- ❑ hearing loss
- ❑ insomnia
- ❑ hemophilia
- ❑ kidney/bladder problems
- ❑ other: _____

Present involvement in other Health Care?

- ❑ Yes specify: _____
- ❑ No _____

Pins/Wires/Prosthetics

_____

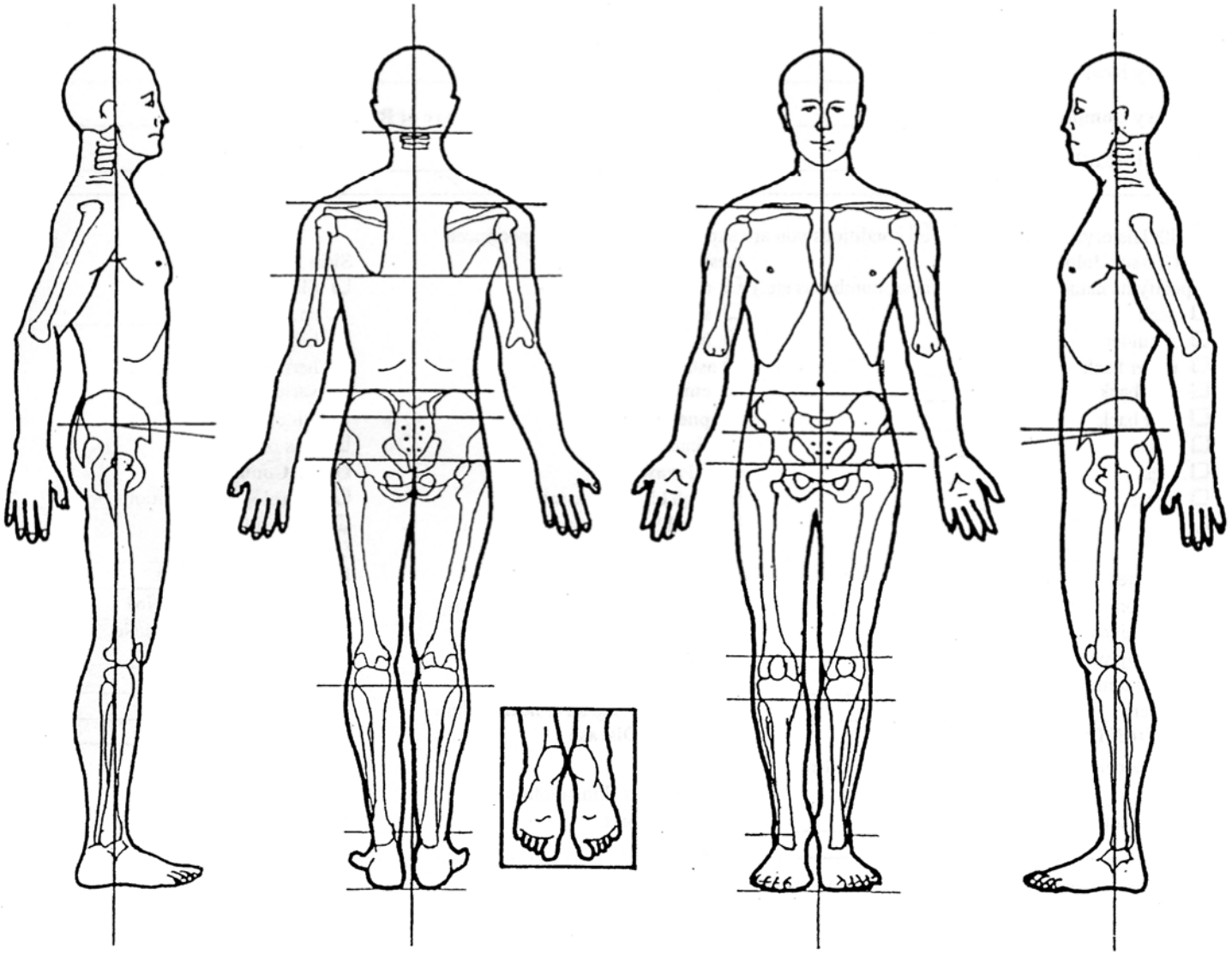
_____

_____

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist and will require my informed consent.

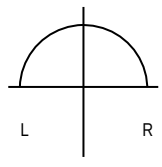
Signature: _____ Date: _____

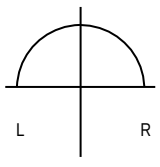
Ceinwen Gobert RMT Name: _____ Date: _____

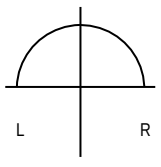


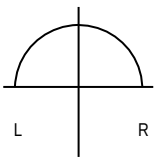
tension: //// trigger point: X tender point: 0 pain: adhesion: parasthesia: scars, bruises, wounds:

Spinal ROM









UPDATED

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____