Medical Case History

For Marcia A. Singh R.M.T.

Name: _____ Date: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Emergency Phone: _____ Contact Person: _____

Height: _____ Weight: _____ Blood Pressure: _____

Date of Birth: _____ Doctor's Name: _____

Doctor's Address: _____ Doctor's Phone: _____

Occupation: _____ Recreational Activities: _____

Reason for seeking Massage Therapy: _____

How did you hear about my clinic?: _____

HEALTH HISTORY: Please check the conditions that you are experiencing.

Head/Neck

Headaches – Type: _____ **Allergies:** _____
Whiplash: _____ **TMJ Dysfunction:** _____
Contacts / Glasses: _____ **Vision Problem:** _____
Cold / Flu: _____ **Earache:** _____
Sinusitis: _____ **Neck Pain:** _____

Therapist Notes

Respiratory

Asthma: _____ **Bronchitis:** _____ **Emphysema:** _____
Pneumonia: _____ **Chronic Cough:** _____
Shortness of Breath: _____ **Congestion:** _____
Smoking: _____ **Heavy:** _____ **Light:** _____

Therapist Notes

Muscles And Joints

Pain: _____ **Stiffness:** _____ **Swelling:** _____
Limitation of movement: _____ **Where?** _____
Muscle Spasm / Cramps: _____
Low Back Pain: _____ **Sciatica:** _____

Therapist Notes

Muscles And Joints
continued

Tendonitis _____ **Bursitis** _____
Poor Posture _____ **Scoliosis** _____ **Kyphosis** _____
DDD / Herniated Disk _____ **Date Diagnosed** _____
Rheumatoid Arthritis _____ **Date Diagnosed** _____
Areas Affected _____
Osteoarthritis _____ **Date Diagnosed** _____
Osteoporosis _____ **Date Diagnosed** _____
Akylosing Spondylitis _____ **Date Diagnosed** _____

Therapist Notes

Cardio-Vascular

High Blood Pressure _____ **Low Blood Pressure** _____
Poor Circulation _____ **Chest Pain** _____
Vascular Disease – Type _____
Dizzyness _____ **High Cholesterol** _____
Heart Disease – Type _____
Phlebitis _____ **Atherosclerosis** _____
Varicose Veins _____ **Date Diagnosed** _____
Areas Affected _____
Stroke _____ **Date Diagnosed** _____
Areas Affected _____

Therapist Notes

Skin

Sensitive Skin _____ **Rash / Eruptions** _____
Bruise Easily _____ **Herpes Simplex** _____
Contagious Conditions _____
Allergies to Oils / Creams _____

Therapist Notes

Digestive

Poor Appetite _____ **Excessive Appetite** _____ **Pain** _____
Difficult Digestion _____ **Nausea** _____
Constipation / Diarrhea _____ **Ulcers – Type** _____
Liver / Gallbladder _____ **Frequent Urination** _____
Kidney / Bladder _____

Therapist Notes

Metabolic Systemic Disorders

Diabetes – Type _____ Date Diagnosed _____
SLE _____ Date Diagnosed _____
PSS _____ Date Diagnosed _____
Gout _____ Date Diagnosed _____
Multiple Sclerosis Date Diagnosed _____
Muscular Dystrophy – Type _____
Date Diagnosed _____

Therapist Notes

Neurological Disorders

Carpal Tunnel Syndrome _____ Date Diagnosed _____
Paralyses _____ Area Affected _____
Seizures _____ Frequency _____
Parkinsons _____ Date Diagnosed _____
Huntingtons Chorea _____ Date Diagnosed _____
Cerebral Palsy – Type _____
Date Diagnosed _____

Therapist Notes

Infectious Diseases

Hepatitis – Type _____ Date Diagnosed _____
HIV _____ Date Diagnosed _____
Tuberculosis _____ Date Diagnosed _____
Others _____

Therapist Notes

Women

Pregnant _____ Trimester _____
Menstruation _____ Painful _____ Heavy _____ Scant _____
Menopause _____ Others _____

Therapist Notes

Surgery / Injury

Type _____
Date _____
Current Symptoms _____

Current Medications and Condition Treated _____

Other Health Care	Chiropractic: Yes _____ No _____ Physiotherapy: Yes _____ No _____ Psychiatric: Yes _____ No _____ Other: _____
Therapist Notes	

Special Note: pins, wires, artificial joints or limbs, special equipment such as wheelchair, walker, cane, etc.

_____

_____

_____

Previous Massage Experience:	**Yes** _____	**No** _____
Good Sleeping Patterns:	**Yes** _____	**No** _____
Regular Eating Habits:	**Yes** _____	**No** _____
Regular Exercise:	**Yes** _____	**No** _____

Cancellation Policy

24 Hour Notice is required for missed or cancelled appointments.

This policy has been implemented due to the length of each appointment (1 Hour Approx.) and the difficulty in rearranging appointment times.

Unfortunately, if proper notice is not given you will be charged for the appointment you booked.

This policy is for the benefit of all, and I thank you for your cooperation.

_____ _____

Signature Date

Information Consent & Accuracy Approval Form

I am aware that this office is keeping personal information as outlined on the reverse of this page for the reasons disclosed. I am aware that the members of the staff of this office may access this information. I give my consent for this information to be collected and disclosed as outlined to me.

___ My file may be used for Quality Audit purposes
___ You may consult another therapist about my case

Date _____ Signature: _____

If Parent or Guardian is signing:

Signature _____ Name: _____

Relationship: _____ ID: _____

Personal information accuracy

I have reviewed my information with the office and accept that it is substantially accurate.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Your Personal Information, the PIPED Act, and Your Therapist

The Personal Information Protection and Electronic Documents Act is a Federal Act that comes into force January 1st 2004. It requires any business or group (non-profit or otherwise) that performs "commercial transactions" (buying, or selling) to take responsibility for the personal information they collect.

Personal information is defined as anything other than the sort of information that appears on a business card or in a phone book. This would include credit card information, dates of appointments, buying preferences, records of past purchases, health information, and any other information that can be connected with a person.

In addition, the PIPED Act gives people more clearly defined rights to control their personal information.

What does this mean to you?

Under the new act you have new rights.

1. You have the right to see any personal information collected about you.
2. Businesses must inform you of what information is collected, why it is being collected, used or disclosed, who will be able to see it, and have your consent to collect it.
3. You have the right to request a correction to any of your personal information
4. You have a process available through the Privacy Commissioner of Canada if our response is not satisfactory.

What happens now?

The first step is providing you with this information sheet. It will inform you of what information we collect, why we collect that information, how long we keep it, how we protect it, who may see it and why we release information when we do.

Next we will ask you to sign a consent form. This form will give us permission to collect that information, share it as appropriate, and will confirm that we have your information correct. Each year we will check with you to see if anything has changed and have you sign again confirming that the information we have is correct.

If you have any questions about the PIPED Act, the information we collect, our policies with regards to privacy, or any other privacy concerns please do not hesitate to speak with Marcia Singh who is the privacy officer for this office.

Where can I get more information?

Privacy Officer for this office
Marcia Singh, 155A Frederick St, Kitchener, ON, N2H 2L3 , (519) 749-8198

Privacy Officer for the College of Massage Therapists of Ontario
Corinne Flitton, 1867 Yonge St. Suite 810, Toronto, ON, M4S 1Y5, (800) 465-1933 x 112

Privacy Commissioner of Canada:
112 Kent St., Ottawa ON, K1A 1H3, (800) 282-1376 http://www.privcom.gc.ca

Who sees your personal information?

Your personal information is not shared with any other organization except as explicitly defined below and in the PIPED Act.

Your patient file is usually only seen by your therapist. Another therapist may see this file if your therapist wishes a second opinion.

With your written permission, information may be shared with an insurance company or lawyer. Different insurance companies and lawyers require different information so this will be addressed on a case-by-case basis.

In very rare cases (such as replacing a hard drive) technical support staff or my bookkeeper may see some parts of your information. All such staff are covered under a contract that ensures they use appropriate levels of confidentiality.

Finally, in extremely rare cases, your records may be subpoenaed by the legal system. In this instance we are obligated to turn over copies of your records to the responsible authorities.

How do we protect your information?

Your patient file is kept in a locking filing cabinet. This cabinet is locked when a therapist is not in attendance.

My computer records are protected by a password. I use my computer to invoices and type medical reports. Two copies are printed, one remains in patient file, the other is mailed to the requesting office (only with your written permission). My next step is to delete the information so that your personal information is kept confidential.

Files may be taken off site in the therapist's locked briefcase for completion or examination at home .

All temporary staff entering this office unattended (such as maintenance and cleaning staff) are bound under contract to respect your information and also operate under the PIPED Act.

When information is to be destroyed, care is taken to ensure that it is properly destroyed (shredded or physically broken) rather then just placed in the garbage.

How long do we keep personal information?

Personal information is destroyed 10 years after your final visit with us. This length of time is mandated by the College of Massage Therapists of Ontario.

What information do we collect and why?

Not all patients will have all of these pieces of information in their files. In the future we will also have copies of any information requests.

Your Patient File

Information	Purpose of this information
First and last name	Patient Identification, insurance billing.
Emergency contact	A contact name and phone number in case of emergencies.
Date of visit with medical notes	By adding a comment at each visit we can track changes in your health and ensure problems are fully resolved.
Medical History	To keep track of anything that may impact your course of treatment.
Consent for information	Proof of accuracy and your consent to our collecting this information.
Consent for treatment	Required by the College of Massage Therapists of Ontario before treatment can begin.

Record of visits	This is kept to allow CCRA (Revenue Canada) to audit our billings.
Record of payments	This information is requires by the College of Massage Therapists of Ontario under the standards of practice.
Birth date	This allows me to send out birthday cards. Required by the College of Massage Therapists of Ontario under the standards of practice.
Date of appointments	This allows me to schedule the therapist's time and provide you with a reminder. Required by the College of Massage Therapists of Ontario under the standards of practice.
Comments	Therapist may make comments in your file based on their conversations with you to improve documentation or record keeping.
Address	Your address allows us to mail you friendly contact (such as our birthday postcards) as well as information that our office feels you may be of interest to you. Required by the College of Massage Therapists of Ontario under the standards of practice.
Phone number	This allows us to remind you of upcoming or missed appointments, or return your calls.