Our Mission: ***Build healthy communities through generations***

Massage Therapy Schedule of Fees

30 Minute Treatment	$60.00
45 Minute Treatment	$75.00
60 Minute Treatment	$95.00
90 Minute Treatment	$132.00
Missed appointment without 24 hours' notice	$40.00

We work as a team!

Naturopathic Medicine: Hormones, bloodwork, family medicine and pelvic health.
Massage Therapy: Muscle health and wellbeing.
Chiropractic: Brain, spinal health and prevention.
Physiotherapy: Injury and rehabilitation

HealthTweak Patient # ____________

PERSONAL INFORMATION

Name: ______________________ Date of Birth: ____________ Age: ________

Address: ______________________ City: ______________ Postal Code: ____________

Home Phone: ______________________ Cell: ______________ Work Phone: ____________

Gender: ____________ Employer: ______________________ Occupation: ____________________

E-mail: ______________________________________ May we contact you via e-mail? Y / N

Spouse/Partner: Y / N Children: Y / N #: ________

Medical Doctor: ______________________ Location: ____________ Last Visit: ______________

Do you want us to communicate with your doctor about your care? Y / N

How did you hear about us? ☐ *Existing patient* ____________ ☐ *Online* ☐ *Doctor* ☐ *Other:*__________

HEALTHCARE HISTORY

Have you ever seen? ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Naturopath

Date of last visit: ____________ ______________ ________________ ____________

Have you ever had? ☐ X- Ray ☐ MRI ☐ CT ☐ Ultrasound

HEALTH CHALLENGES

What is the nature of your visit?

☐ Wellness (help me to always be at the highest level of health)

☐ Restorative (help me to restore my health)

☐ Injury (help me to get out of pain)

Please explain your health challenges in order of importance to you:

1) ____

When did it begin? ____________________ Have you had this problem before? ________________

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? __________________________

What does this challenge stop you from doing? ____

Have you seen anyone about this challenge? ____

Prior treatments and results? ____

2) ____

When did it begin? _______________________ Have you had this problem before? _________________

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? ____________________________

What does this challenge stop you from doing? ____

Have you seen anyone about this challenge? ____

Prior treatments and results? ____

3) ____

When did it begin? _______________________ Have you had this problem before? _________________

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? ____________________________

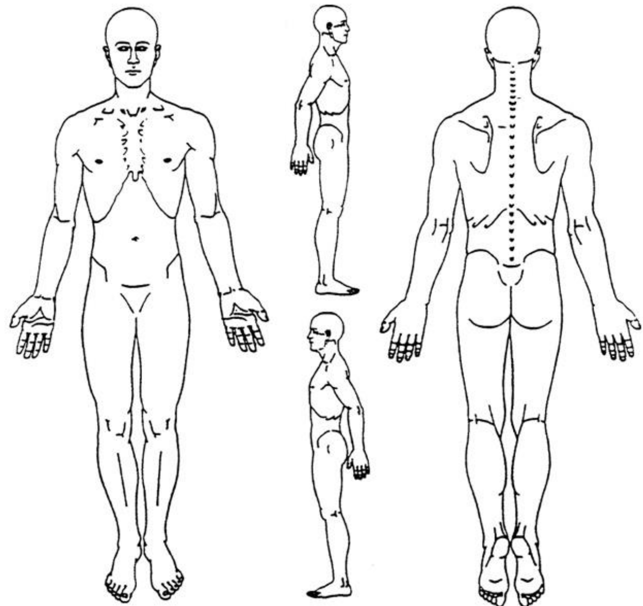
What does this challenge stop you from doing? ____

Have you seen anyone about this challenge? ____

Prior treatments and results? ____

Use letters to indicate type
and location of discomfort:

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



HealthTweak Patient # ___________

HEALTH INFORMATION

Past injuries (birth complication, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, reactions to medication, environmental toxins):

Please list any health conditions treated for in the past year:

Please list any hospitalizations including year:

Medication and Supplements

Please list any *medications* you are taking: *Purpose and dose*:

Please list any *supplements* you are taking: *Purpose and dose*:

Gynecology and Pregnancy

Age of first period: ____________ Any chance you may be pregnant? Y ☐ N ☐ If so, # of weeks______

First day of your last period? ______________ How long does your period last? ____________________

How long is your cycle (first day of menses to last day before they start again)? ____________________

Are your menses? Irregular ☐ Painful ☐ Heavy ☐

Do you experience hot flashes? Y ☐ N ☐

Date of last PAP : _________________ Normal cells ☐ Abnormal cells ☐

Are you using any method of birth control? If yes, what type?______________________________

How long have you been using this method? ____

Do you experience any changes with your body or emotions prior to your menses/period or at any specific point in your cycle? ____

Have you ever been pregnant? If yes;

# of live pregnancies __________ # of miscarriage ______________ # of abortions ________________

HealthTweak

Patient # ___________

HEALTH CONDITIONS

Please check the following that apply to you:

- ☐ Seizures
- ☐ Allergies ______________
- ☐ HIV
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Thyroid Disease
- ☐ Cystic Fibrosis
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Other Major Illness
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Venereal Disease

General

- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Nausea/vomiting
- ☐ Fevers
- ☐ Lumps
- ☐ Masses
- ☐ Dizziness
- ☐ Double vision
- ☐ Problems swallowing
- ☐ Problems talking
- ☐ Loss of consciousness
- ☐ Loss of balance

Gastrointestinal

- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating/Gas
- ☐ Laxative use
- ☐ Bad Breath
- ☐ Nausea/vomiting
- ☐ Abdominal cramps/pain
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Blood in stool

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Pain w/breathing
- ☐ Mucous Production

Learning Disability

- ☐ ADHD
- ☐ Dyslexia
- ☐ Memory loss
- ☐ Autism spectrum

Neuropsychological

- ☐ Depression
- ☐ Disinterest
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Concussion
- ☐ Fainting
- ☐ Dizziness
- ☐ Neuropathy
- ☐ Numbness
- ☐ Neurological condition (MS, ALS)

Ear/Nose/Throat/Eyes

- ☐ Vision loss/blurring/pain
- ☐ Hearing loss/ringing
- ☐ Sinus infections/problems
- ☐ Ear infections
- ☐ Nose Bleeds
- ☐ Problems with teeth
- ☐ Night Blindness
- ☐ Sores on lips, tongue or m
- ☐ Facial Pain
- ☐ Recurrent sore throat

Genitourinary

- ☐ Increased frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Bladder/Yeast Infections
- ☐ Genital Sores
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Urgency to void
- ☐ Wake at night to void

Cardiovascular

- ☐ Chest pain
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Swelling hands/feet
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Impotence

Adrenal

- ☐ Mental fog
- ☐ Poor focus
- ☐ Quick to react
- ☐ Low energy
- ☐ Fatigue
- ☐ Headache
- ☐ Chest tightness
- ☐ Restless legs
- ☐ Susceptible to stress

Doctor Section

- ☐ Vascular
- ☐ Metabolic
- ☐ Aneurism
- ☐ Neoplasm
- ☐ Infection
- ☐ Congenital
- ☐ Trauma

HealthTweak

Patient # ____________

LIFESTYLE

What is the biggest stressor in your life? ☐ Family ☐ Work ☐ Social ☐ Financial ☐ Health ☐ Time

What do you love to do in your spare time (hobbies)? ____

How often do you exercise? ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week ☐ Infrequently

Smoke? Y / N # Packs/week _______ Drink alcohol? Y / N # Drinks/week ______

Recreational Drug use: ______________________

Hours of sleep? _______ Feel rested? ________

How often do you get cold/respiratory illness per year? ________

Where is your current level of health? (circle) 1 Very low 2 Poor 3 OK 4 Good 5 Excellent

If you had excellent health, what would you love to be able to do? ________________________________

FAMILY PROFILE

At Health*Tweak* we are here to help you and family live healthy and happy. Please mention below any health conditions or concerns they may have:

Children: ____

Spouse/Partner: ____

Other family members: ____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing services within his or her scope of practice as defined by the College of Massage Therapists of Ontario. I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy.

I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle tenderness, light-headedness, or dizziness.

I understand that the 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 medical examination.
I have completed my medical history form and have disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history.

I have read the above consent. I agree to this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that at any time I may withdraw my consent, and treatment will be stopped. I

understand that failure to provide 24 hours notice prior to cancelling an appointment may result in a charge of a $40.00 missed appointment fee.

I understand that because of the nature of HealthTweak Wellness Group, patient files and information contained in files may be shared among practitioners for the mutual benefit of patient treatment. All information will remain confidential. I understand that written consent must be obtained for a practitioner to remove/transfer file information outside of HealthTweak Wellness Group.

PERSONAL HEALTH INFORMATION CONSENT

I understand that Health*Tweak* is my *health information custodian*. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons.

I understand that to provide me with massage therapy, chiropractic, physiotherapy or any other health care services, Health*Tweak* will collect personal information about me (e.g., birth date, home contact information, health history, etc.).

I understand that the Health*Tweak* will only collect, use or disclose my personal health information with my express or implied consent, unless a collection, use or disclosure without consent is permitted or required by law.

A termination of therapist-patient relationship may occur under following circumstances: 1. practitioner can't provide effective treatment, 2. patient does not pay for care, 3. patient is physically or verbally abusive the therapist.

Client Signature: ___________________________ Date: ________________________

Therapist Signature: _________________________ Date: ________________________

Thank you for completing this form.
If you would like us to *direct bill* your insurance, please provide your insurance information to our receptionist.