The Collection, Use and/or Disclosure of Personal Information

WAKE Wellness only collects information relevant to the services we provide and has a comprehensive privacy policy in accordance with the current Federal and Provincial privacy legislations, the standards of our regulatory body, The College of Massage Therapists of Ontario (CMTO), the Massage Therapy Act, and the Regulated Health Professions Act.

At WAKE Wellness, Melissa Verburgh, RMT is the Health Information Custodian (HIC).

Why does WAKE Wellness need to collect, use and/or disclose your Personal Information?

- To provide safe and efficient treatments through a baseline of health information
- To advise you of treatment options and/or communicate with other regulated health professionals in your "circle of care"
- To allow WAKE Wellness to contact you
- To invoice for goods and services and collect unpaid accounts
- To comply with The CMTO who conduct regular inspections across the province

How will WAKE Wellness protect your Personal Information?

- Information is either supervised or secured in a locked area
- Staff and volunteers are trained in accordance with our privacy policy
- External agencies must enter privacy agreements with us
- Files are kept for at least 10 years after your last appointment with us
- Paper information is destroyed by shredding

Consent for the Collection, Use and/or Disclosure of Personal Information

I have reviewed this information sheet explaining how and why WAKE Wellness will collect, use and/or disclose my personal information. If I need more information there is a Privacy Policy I can read at any time, which addresses these issues in detail. You can also contact the *Information and Privacy Commissioner/Ontario* at 2 Bloor Street East, Ste. 400, Toronto, Ontario M4W 1A8; Tel.: 1-800-387-0073; email: info@ipc.on.ca

By signing this Consent I agree to the collection, use and/or disclosure of my personal information for the purposes listed above and to the cancellation policy below.

Cancellation Policy

Please be advised that WAKE Wellness requires ***24hrs*** notice for cancelled appointments. Appointments missed without notification will be billed accordingly.

Printed Name: _____ Signature: _____

HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. If your health status changes in the future, please let us know.

Name: _____ Today's Date:_____ Birth Date(d/m/y): _____

Address: _____ Postal Code: _____

Phone:(home) _____ (Cell)_____(work)_____

Email / Fax: _____ Occupation: _____

How did you hear about us? _____

Have you had massage before? Y N

Please indicate conditions you are experiencing or have experienced.

Cardiovascular

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ chronic congestive heart failure
- ❑ heart attack
- ❑ phlebitis/varicose veins
- ❑ stroke/CVA
- ❑ pacemaker/similar device
- ❑ heart disease

Is there a family history of any of the above? Yes ____ No ____

Infections

- ❑ hepatitis
- ❑ TB
- ❑ HIV/AIDS
- ❑ skin conditions _____ (eg. psoriasis, eczema)

Respiratory

- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ chronic cough

Is there a family history of any of the above? Yes ____ No ____

Other Conditions

- ❑ loss of sensation _____
- ❑ diabetes (onset:_____)
- ❑ allergies/hypersensitivities
- ❑ epilepsy
- ❑ cancer _____
- ❑ arthritis _____

Is there a family history of arthritis? Yes _____ No _____

Head / Neck

- ❑ history of headaches
- ❑ history of migraines
- ❑ vision problems
- ❑ vision loss
- ❑ ear problems
- ❑ hearing loss

Women

- ❑ pregnant-due date _____
- ❑ gynaecological conditions

In General

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____ _____

Current medications and the conditions they treat:
_____
_____
_____

Are you currently receiving treatment from another health care professional? Yes _____ No _____
If yes, for what? _____
_____
Surgery – date: _____
nature: _____

Injury – date: _____
nature: _____

Do you have any other medical conditions? (eg. Digestive conditions, haemophilia, osteoporosis, mental illness) Yes _____ No _____
If yes, what? _____

Do you have any internal pins, wires, artificial joints or specia equipment? Yes _____ No _____
If yes, what? _____
__
where? _____

What is the reason you are seeking massage? _____
_____
_____