Nature Doctors
Naturopathic Family Medicine Inc.
Unit 7-1200 Waverley St
Winnipeg, Manitoba R3T 0P4
Phone: (204) 943-6079
Fax: (204) 489-3128

Privacy Policy and Consent to Treatment

Privacy of your personal information is important to us to providing you with quality health care. We understand the importance of protecting your personal information. All information collected will be kept confidential unless requested by you or required by law.
Only the necessary information will be collected about you. This information is used to assess your health care needs, advise you of treatment options and provide you with safe and efficient health care. Collected information will also enable us to contact you and to communicate with other health care providers treating you for achieving the best health care possible. An ongoing record will be kept of treatments to track progression. Your massage therapist respects your right to modify, refuse, or terminate treatment, regardless of prior consent given. You will have access to these records at anytime and can request a copy for an appropriate fee.

If there are any changes is your health status it is important that you notify your therapist immediately. Some conditions may present complications or contraindications to treatment. Informing us of these changes will enable us to modify your treatment plan to avoid any problems. Your therapist has the right to stop or modify treatments at any time if you present with a contraindicated condition.

The treatment will be provided only when there is reasonable expectation that the treatment will be beneficial to the patient. Before, during and/or after therapy, we encourage you to communicate to the therapist any aspect of the treatment in which you have concerns and/or questions. Proper draping is always provided to ensure safety, comfort and privacy for all patients. Clients are asked to disrobe in private and prepare themselves on the massage table. You may choose to remove or leave on clothing, according to your own comfort level.

Your therapist can not diagnose any medical conditions. Your therapist will adhere to the Standards of Practice and Code of Ethics outlined by the Massage Therapy Association of Manitoba.

Cancellation Policy

If you need to cancel/reschedule an appointment two business days notice is needed. We must receive your call by 5:30pm two days before the scheduled appointment or 100% of the fee will be charged.

Declaration of Consent

I have reviewed the above information and agree to give my consent to collect personal information and consent to treatment. I understand that I can withdraw my consent and discontinue participation in these treatments at any time.

I AGREE to pay my full account at the time of each visit or treatment. I understand that I must give 2 full business days to change or cancel an appointment. If I do not follow this cancellation policy, or simply do not show up for my appointment, I agree to pay the full cost of the appointment.

Client Signature____ Date ____________________________________

PERSONAL INFORMATION

Name:___________________________________ Address:____

Home Phone #:____________________ Work Phone #:___________________ Cell Phone #:_____________________

City:___________________________________ Province:___________________ Postal Code:_____________________

Date of Birth:___________________________ Email Address:____

Age:____________________________________ Gender: ____

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Occupation:______________________________ Employed by:____

Recreational Activities:____

Where did you first hear about our clinic?:____

What is your main concern?:____

HEALTH HISTORY: Please check any that apply

Head/Neck:

Headaches	[ ]
Migraines	[ ]
Sinus Problems	[ ]
Vision Problems	[ ]
Earaches	[ ]
Herniated Disc	[ ]
TMJ syndrome	[ ]

Respiratory:

Asthma	[ ]
Chronic Cough	[ ]
Chronic Bronchitis	[ ]
Shortness of Breath	[ ]
Smoking	[ ]

Muscles/Joints: (please specify which joint)

Pain	[ ]
Stiffness	[ ]
Swelling	[ ]
Limited Movement	[ ]
Arthritis	[ ]
Whiplash	[ ]
Scoliosis	[ ]

Digestion:

Constipation	[ ]
Diarrhea	[ ]
Crohn's/Colitis	[ ]
Poor Appetite	[ ]
Excessive Appetite	[ ]

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Cardiovascular:

High Blood Pressure [ ]
Low Blood Pressure [ ]
Heart Disease [ ]
Heart Attack [ ]
Stroke [ ]
Varicose Veins [ ]
Poor Circulation [ ]
Dizziness [ ]

Medications:

Medication:________________________________
Condition Treated:__________________________
Medication:________________________________
Condition Treated:__________________________
Medication:________________________________
Condition Treated:__________________________

Surgeries/Major Injuries/Car Accidents:

Type:________________ Date:________________
____
Type:_________________ Date:_______________
____

Other Conditions:

Allergies/Sensitivities [ ]
Please list:____
Anaphylaxis [ ]
Kidney/Bladder [ ]
Liver [ ]
Diabetes [ ]
Fibromyalgia [ ]
Cancer [ ]
Infectious Disease [ ]
Osteoporosis [ ]

Women:

Pregnant; due [ ]
# of children [ ]
Menstrual pain [ ]
Menopause [ ]

Skin Conditions:

Eczema [ ]
Contagious condition [ ]
Psoriasis [ ]
Sensitive [ ]

Other:

Previous massage [ ]
Regular exercise [ ]
Good eating habits [ ]
Good sleeping habits [ ]

Of Special Note: (presence of pins, wires, artificial joints, special equipment such as wheelchair, walker, cane, etc.)

____

I have filled out this form to the best of my ability. All information provided is accurate to the best of my knowledge. I will alert my therapist of any changes in my health status.

Client Signature____ Date ___________________________