M E T C A L F E   M A S S A G E   T H E R A P Y   C L I N I C

331 Cooper St., Suite 702, Ottawa, Ontario K2P 0G5   (613) 235 – 2377 www.metcalfemassage.com

Name:____ Today's Date: ________________________
(day/month/year)

Address & Postal Code: ____

Tel. (home) ____________________ Tel. (work): ____________________ Tel. (cell): ____________________

Date of Birth: _______________ Occupation:_____________________ Email: __________________________
(day/month/year)

Doctor's Name: ____ Tel. _______________________________

Doctor's Address: ____

Emergency contact: ____ Tel. ___________________________

Referred by: (Doctor, Physio, Friend, etc.)____

Confidential Health History

Have you received massage therapy before?   Yes   No. If yes, how often? ______________________________

What brings you in for a massage?: ____

General Health Status: Poor   Fair   Good

Please indicate if any of the following apply to you:

Injuries: (sprains, strains, fractures, dislocations)
Type: Date:

_____________________________ _______________

_____________________________ _______________

_____________________________ _______________

Current Medications/Vitamins/Supplements:
Name: For what condition:

____

____

____

Surgery:
Type: Date:

_____________________________ _______________

_____________________________ _______________

_____________________________ _______________

Exercise or Other Recreation:
Type: Frequency:

___________________________ _________________

___________________________ _________________

___________________________ _________________

___________________________ _________________

Of Special Note: (pacemeaker, pins, wires, artificial joints, limbs, or special equipment: walkers, canes etc.)

____

Have you received any of the following treatments?

Physiotherapy
name:____
condition: ______________________ Date: _________

Psychotherapy
name: ____
condition: ______________________ Date: _________

Chiropractic
name: ____
condition: ______________________ Date:_________

Other(s) (Naturopathy, Acupuncture, etc.)
type: ____
name: ____

Date Updated and initials of client:
1: ________________________
2: ________________________
3: ________________________
4: ________________________
5: ________________________

*Please indicate '**C**' for current, '**P**' for past and '**F**' for family history for each condition.*

Muscles/ Joints / Nerves
Back, Neck and Head

__ tension headaches
__ migraine headaches
__ neck pain/injury
__ whiplash
__ sinus conditions
__ tooth / jaw / ear pain
__ vision or hearing loss / dizziness
__ tinitis
__ head trauma / concussion
__ back pain / injury
__ strain / sprain
__ degenerating discs
__ sciatica
__ scoliosis

Limbs (shoulders /arms /hands /hips/ legs / feet)

__ strains/sprains
____
____
____
__ fractures/bone disease_____________
__ pain/weakness/ tingling/ numbness
____
__ muscle/nerve disease______________
__ tendinitis / fibrositis / bursitis
__ hip pain

Heart / Circulation

__ high blood pressure
__ low blood pressure
__ bruise easily
__ cold hands & feet
__ phlebitis
__ chest pain / angina
__ swelling: ________________
__ heart disease
__ heart attack
__ stroke
__ chronic congestive heart failure

Lungs / Respiration

__ asthma / bronchitis
__ chronic cough
__ allergies
__ frequent colds
__ smoking
__ emphysema
__ shortness of breath

Skin

__ open sores / cuts / warts
__ skin condition / disease
__ rashes / athlete's foot
type: ______________________

Digestion / Uro-Genital Systems

__ difficult digestion
__ constipation (chronic)
__ rapid weight loss
__ diarrhea (chronic)
__ ulcers ____________________
__ liver / gall bladder ___________
__ kidney / urinary bladder
__ bloating / gas

Women

__ menstrual issues
__ pregnant ? due date__________
__ menopausal issues
Other ________________________

Men

__ prostate issues
Other__________________________

General Symptoms

__ osteo / rheumatoid arthritis
____
__ osteoporosis
__ nausea
__ fatigue
__ anxiety
__ changes in appetite
__ stress
__ loss of co-ordination
__ insomnia
__ epilepsy
__ diabetes: Type: __________

Use this space to elaborate on any of the above conditions: ____
____

Are there any other medical conditions to bring to our attention? (cancer, haemophilia, infectious diseases, i.e. tuberculosis, hepatitis, HIV, herpes, etc.) : ____
____

The information that you give on this form will be confidential. However, if you receive treatments from other therapists at this clinic, this information will be shared with them in confidence. No consultation with any other health care professional will occur without your prior written authorization.

Therapists at the Metcalfe Massage Therapy Clinic will offer suggestions for assessment and treatment based on your health and comfort. You have the right to stop or ask for a change in assessment and/or treatment at any time and for any reason.

Cancellation Policy

The Metcalfe Massage Therapy Clinic has a **24 hour** cancellation policy. If you miss or cancel an appointment with less than 24 hours notice you will be charged the stipulated cancellation fee.

Date: ________________________________ Signature: _______________________________________