

METCALFE MASSAGE THERAPY CLINIC

180 Metcalfe St., Suite 607, Ottawa, Ontario K2P 1P5 (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: (pacemaker, 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: _____