



SHEDDON PHYSIOTHERAPY AND SPORTS CLINIC

Oakville Medical Centre 331 Sheddon Ave., Suite 304. Oakville, Ontario L6J 1X8

TEL: (905) 849- 4576 FAX: (905) 849-7856 www.sheddonphysio.com

Personal Information

Name: _____ Today's Date: _____

Address: _____ City: _____

Postal code: _____ Telephone (Home): _____

(Work): _____ (Cell): _____

Email Address: _____

Date of Birth: (mm/dd/yy) ___/___/___ Gender: Male ___ Female ___

Whom shall we thank for referring you for care? _____

Current Health Condition

Reason(s) for consulting our office today: _____

When did this begin? _____

Has it occurred before? _____

Please use the diagrams to illustrate your concern(s):

How would you describe it? Achy ___ Stabbing ___ Sharp ___

Tingling ___ Numb ___ Dull ___ Throbbing ___ Other _____

Is it worsening? ___ Getting better? ___ Unchanged? ___

What aggravates it? _____

What relieves it? _____

Can you relate it to a fall ___ sports injury ___ hobby ___

Work accident ___ car accident ___ Other _____

What have you tried to resolve this? _____

Current drugs: Pain killers ___ anti inflammatories ___

Muscle relaxants ___ Other _____

Other health concerns: _____

Your Health History

Have you had Massage Therapy previously? Yes ___ No ___

Approximate date of your last massage: _____

Do you have any surgically replaced joints or implants _____ a pacemaker ___

Please list any past surgeries: _____

Please list any prescription medications you are taking: _____

Have you been diagnosed with any of the following conditions: osteoporosis ___

arthritis ___ high blood pressure ___ low blood pressure ___ stroke ___

neurologic disorders ___ Multiple Sclerosis ___ epilepsy ___ cancer ___

varicose veins ___ Auto-immune disease ___ other: _____

Please list any allergies you have: _____

Do you have any relevant family history related to your condition? _____

Waiver of Consent

I consent to treatment at Sheddon Physiotherapy and Sports Clinic by the Massage Therapist.

I understand that I am allowed to withdraw my consent at any time and will inform the therapist immediately if I do.

Name (print)

Signed