SHEDDON PHYSIOTHERAPY AND SPORTS CLINIC

1300 Cornwall Rd, Suite 103, Oakville, Ontario, L6J 7W5

Massage Therapy 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. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss
Name ______________________ Phone # ______________________
Address ______________________ City: ______________________ Postal Code: ______________
Email address: ______________________
Occupation ______________________ Date of Birth (D.O.B) ______________________
How did you hear about us? ______________________
Have you received massage therapy before? ☐ Yes ☐ No
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please providetheir name ______________________

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis / varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

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

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

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

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, where? ______________________
- ☐ Diabetes, onset: ______________
- ☐ Allegies / Type of reaction ______________________
- ☐ Epilepsy
- ☐ Cancer, where? ______________
- ☐ Skin conditions, where? ______________ ______________________
- ☐ 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: ______________
- ☐ Gynaecological conditions, what? ______________________

Overall, how is your health? ______________________

Primary Care Physician: ______________________

Address: ______________________

Current Medications: ______________________

Condition it treats: ______________________

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? ______________________

Surgery – date ______________________
nature: ______________________

Injury – date ______________________
nature: ______________________

Did you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
☐ Yes ☐ No what? ______________________

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
What? ______________________
Where? ______________________

What is the reason you are seeking massage therapy?
Please indicate the location of any tissue or joint discomfort.
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Please note that all appointments at Sheddon Physiotherapy & Sports Clinic <u>required a 24HR cancellation notice.</u> Otherwise the full treatment fee will be charged.I have stated all medical conditions and will update my therapist of any changes in my health status. I have the right to stop, change, requestmodification of my treatment within the scope of practice of the therapist. I consent to be treated by a Registered Massage Therapist.

Signature: ______________________ Date: ______________________

OFFICE USE ONLY: Date of initial health assessment: ______________
Update 1: ______________
Update 2: ______________

OFFICE USE ONLY: Date of initial health assessment: __________________
Update 1: __________________
Update 2: __________________