

Natural Balance Massage Therapy Centre

130 Albert Street
Suite B6
Ottawa, Ontario K1P 5G4
Phone: (613) 566-3000

Date: _____ Referred By: _____
Name: _____ Date of Birth: _____
Address: _____
City/Province: _____ Family Physician: _____
Postal Code: _____ Phone: _____
Phone (day): _____ Occupation: _____
(evening): _____
(cellular): _____
Email: _____

Emergency Contact: _____ Relationship: _____
Phone (day): _____ (evening): _____

Have you ever received a professional massage? yes no If yes, date of last massage: _____

Are you currently involved in treatment with another health care practitioner(s)? yes no
If yes, for what condition(s)? _____

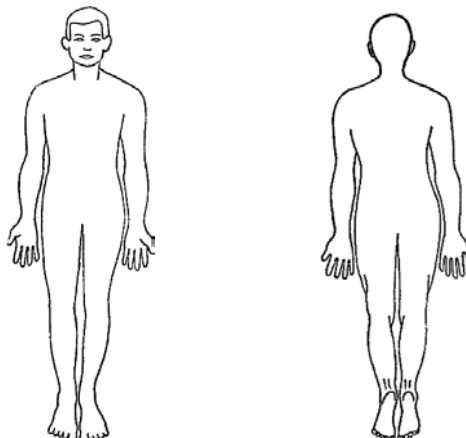
Are you currently taking any medication(s)? yes no
If yes, specify: (include aspirin, ibuprofen, etc...) _____

List ANY allergies or hypersensitivity reactions:

List stress reduction and exercise activities. Include frequency:

Please check the areas of your body you give consent to receive massage:
 back legs buttocks arms abdomen chest neck head face

Please circle current symptomatic areas in your body on the diagram:



(Please complete both sides of page)

Have you ever been diagnosed with or have you ever experienced any of the following:

CARDIOVASCULAR/CIRCULATORY:

_____ high blood pressure _____
_____ low blood pressure _____
_____ chronic congestive heart failure _____
_____ heart disease _____
_____ phlebitis _____
_____ presence of pacemaker or similar device _____
_____ varicose veins _____
_____ other _____

RESPIRATORY:

_____ chronic cough _____
_____ bronchitis _____
_____ shortness of breath _____
_____ asthma _____
_____ emphysema _____
_____ other _____

MUSCULOSKELETAL:

_____ bone or joint disease _____
_____ joint instability _____
_____ tendonitis _____
_____ bursitis _____
_____ fractured bones _____
_____ jaw pain (TMJ) _____
_____ sprains/strains _____
_____ spasms/cramps _____
_____ other _____

SKIN:

_____ lack of sensation/numbness _____
_____ contagious conditions _____
_____ rashes _____
_____ athletes foot _____
_____ warts _____
_____ frostbite _____
_____ other _____

INFECTIOUS DISEASE:

_____ infectious skin conditions _____
_____ tuberculosis _____
_____ hepatitis _____
_____ HIV _____
_____ other _____

OTHER:

_____ cancer/tumours _____
_____ undiagnosed lump _____
_____ diabetes _____
_____ drug/alcohol addiction _____
_____ nicotine/caffeine addiction _____
_____ depression _____
_____ eating disorder _____
_____ other _____

Have you ever suffered from:

_____ heart attack _____
_____ stroke _____

Are you, or could you be pregnant? ___yes___no If yes, how many weeks? _____

Do you have any internal pins, wires, artificial joints or special equipment? ___yes___no

If yes, specify: _____

List any surgeries (include date and treatment received):

List any accidents / injuries (include date and treatment received):

Please list any other diagnosed diseases or medical conditions not specified anywhere above.

I declare that all above information is true, and if it should change, it is my responsibility to notify the therapist of these changes prior subsequent treatment. All information I provide to the therapist, and / or this office, will be held in the strictest of confidence. Discussion of my medical information with another health care provider outside this office will only occur with my prior written and signed consent. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service. I understand I may withdraw my consent for treatment at any time, at which point the treatment will end immediately.

Signature: _____ Date: _____

24 hours notice required to change or cancel an appointment otherwise half the appointment fee will be charged.