PERTH Family Health Centre
PERTH MASSAGE THERAPY

Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____
Update 5_____

Health History Form

The information request 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 confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____
Address: _____
Phone Number : _____
Date of birth: _____
Occupation: _____

Salutation: Miss MS Mrs Mr _____
Pronouns: _____
Email: _____
Did a health care practitioner refer you for massage? Yes No
If yes, please provide their name and address
_____
_____

Have you had massage therapy before? Yes No

Please indicate conditions you are experiencing or that you have experienced

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
□ herpes

Other Conditions
□ loss of sensation, where?
_____
□ diabetes, onset: _____
□ allergies/hypersensitivity to what?
_____
type of reaction:
_____
□ epilepsy
□ cancer, where?
_____
□ skin conditions, what?
_____
□ 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

Reproductive Health
□ pregnant, due: _____
□ gynecological conditions, what?
_____
Overall, how is your general 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? _____
_____

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) Yes No what?
_____
_____
_____
Do you have any internal pins, wires, artificial joints or special equipment? Yes No
what? _____
where? _____

Surgery, Date(s) and Nature: _____

_____

Injuries, Date(s) and Nature: _____

_____

Current Health	Poor	Fair	Good	Excellent
Purpose of this visit	Treatment		Relaxation	Both

Which, if any, of the following symptoms are you experiencing? Please check all that apply

Dull ache	Tingling	Twitching
Cramping	Burning	Stabbing
Sharp pain	Stiffness	Radiating pain
Swelling	Weakness	Numbness

Where are you experiencing symptoms? Please check all that apply

Head	Wrists	Hips	Toes
Neck	Hands	Pelvis	
Shoulders	Upper back	Legs	
Elbows	Mid back	Calves	
Arms	Lower back	Feet	

Additional space for medications, please list

Additional Information: _____

_____

_____

_____

_____

I hereby request and consent to the performance of the assessment and treatment by the Registered Massage Therapist. I have had an opportunity to discuss the nature and purpose of the assessment and treatment. I understand the benefits and risks. I also understand that all steps necessary will be taken to minimize any risks. I have had an opportunity to ask questions and I am satisfied with their responses. I understand that future modifications to my treatment will be undertaken only upon verbal consent. I hereby consent to the treatment discussed and I intend this consent to cover the entire course of treatment. I certify that, to the best of my knowledge, the above information is complete and accurate.

Client Signature: _____ Date: _____

24 hours' notice is required for cancellations; in the event of a missed massage therpy appointment or late cancellation you will be charged the full appointment fee unless the appointment space is filled. Thank You for respecting your therapist's time.