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, and you may withdraw your consent at any time.

Name: _____
Address: _____
Phone Number : _____
Date of birth: _____
Occupation: _____
Have you had massage therapy before? Yes No
Primary reason(s) for seeking massage therapy ____
_____
Accessibility needs: _____
_____

Salutation: _____ Pronouns: _____
Email: _____
Did a health care practitioner refer you for massage? Yes No
If yes, please provide their name and address _____
_____
Overall, how is your general health? _____
Primary Care Dr: _____
Address: _____
Emergency Contact: _____
_____

Please indicate conditions you are experiencing or that you have experienced that may impact your massage therapy care:

Cardiovascular: Do you have any heart or circulation concerns? (e.g. High blood pressure, blood clots) _____
_____
_____
_____

Is there a family history of any cardiovascular issues? Yes No

Respiratory: Do you have any lung or breathing issues? (e.g. asthma)
_____
_____
_____

Is there a family history of breathing issues? Yes No

Skin conditions: Do you have any skin conditions that may impact your reaction to massage? (e.g. bruise easily, rashes) _____
_____
_____

Is there a family history of arthritis? Yes No

Muscle, joint or bone issues: (e.g. arthritis, muscle strain) _____
_____
_____
_____

Allergies: _____
_____

Do any allergies need an epi-pen? Yes No

Neurological Conditions: (e.g. Dizziness, numbness, seizures, stroke) _____
_____
_____
_____

Reproductive Health: (e.g. Pregnancy, menstrual concerns, menopause) _____
_____
_____
_____

Do you have any other conditions that may impact your massage therapy care?
_____
_____
_____

In the last year have you received treatment from another health care professional? Yes No
If yes, for what? _____
_____

Are you taking any medications or substances that may affect your sensitivity, healing, or ability to receive massage? (e.g. blood thinners, corticosteroids, pain medications, recreational drugs, muscle relaxants, nerve blocks) Yes No
_____
_____

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) Yes No
If yes, please provide more information _____
_____
_____

Do you have any internal pins, wires, artificial joints, or special equipment? Yes No
what? _____
where? _____

Surgery, Date(s) and Type/Nature: _____
_____
_____

Recent or current injuries, date(s) and nature: _____
_____
_____

Were recent injuries sustained in a motor vehicle accident or at work? Yes No _____

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

Chronic pain	Numbness
Fatigue	Inflammation
Tension	
Swelling	

Where are you experiencing symptoms? Please list all areas that apply _____
_____
_____
_____

Physical symptoms related to Mental Health (e.g. stress, anxiety, depression): Mental health concerns can contribute to physical symptoms such as musculoskeletal pain, and many of these physical symptoms can be addressed by massage therapy. Are you experiencing physical symptoms such as fatigue, tension or sleep disturbances that may relate to mental health? Yes No If yes, please describe _____
_____

Additional Information: _____
_____
_____
_____
_____

I have read the above information and have stated all my previous and current medical conditions. I will update the Registered Massage Therapist regarding any updates in my condition as soon as possible.

In order to provide treatment, this clinic must collect personal information. I understand that all information that I provide will be kept confidential unless required by law. I understand that I will be asked for written authorization before this information can be released.

I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period. If an appointment is cancelled within 24 hours and we are unable to fill the appointment time you will be charged the full appointment fee. If the appointment can be filled there will be no charge. You may register for email reminders for your appointments but please note you are responsible for the appointment even if reminders aren't sent.

I certify that, to the best of my knowledge, the above information is complete and accurate.

Signature: _____ Date: _____