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: _____ Salutation: Miss Ms Mrs Mr _____

Address: _____ Phone #: _____

Email: _____ Date of Birth: _____

Occupation: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage? Yes No

If yes, please provide their name and address

_____

Please indicate conditions you are experiencing or 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
□ HIV
□ 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: _____
□ gynaecological 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, haemophilia, 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 | Lower back | Calves |
| Neck | Hands | Hips | Feet |
| Shoulders | Upper back | Pelvis | Toes |
| Elbows | Mid back | Legs | Other |

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 appointment or late cancellation you will be charged half of your full appointment fee. Thank You for respecting your therapist's time**.