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

Name: _____ Phone # _____
Address:_____
Occupation:_____ Date of Birth: _____
Have you received massage therapy before? □ Yes □ No
Did a health care practitioner refer you for massage therapy? □ 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

Women
- □ 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? _____
_____

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

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? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

Notes:

Date of initial Health History:_____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

PERTH
Family Health Centre
PERTH MASSAGE THERAPY

Additional space for medications please list:

Current Health: Poor Fair Good Excellent

Purpose of this visit: Treatment Relaxation Both

Which if any of these symptoms are you experiencing? Check all that apply

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

Where are you experiencing these Symptoms? Check all that apply

Head	Wrists	Low-back	Calves
Neck	Hands	Hips	Feet
Shoulder	Upper-back	Pelvis	Toes
Elbows	Mid-back	Legs	Other

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 therapists time.