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

Confidential Massage Therapy Health History Form

Sherri Flegel RMT
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The information request below will assist us in treating you safely. An accurate health history is important to make certain the treatment received is correct. Feel free to ask any questions about the information being requested.
All information gathered for this treatment is confidential unless allowed or required by law. Your written permission will be required to release any information. If your health status changes in the future it is important that you inform us.

Name: _____Occupation: _____
Address: _____City:_____Postal Code: _____
Date of Birth:_____Phone #: _____Email: _____

Have you received massage therapy before? ☐ Yes ☐ No
How did you hear about Sherri Flegel, RMT? _____
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address: _____

Please circle all 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
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

Head / Neck
history of headaches
history of migraines
vision problems
vision loss
ear problems
hearing loss
concussions

Women
pregnant? due:_____
gynaecological conditions (list) : ____
_____

Infectious Disease
hepatitis
tuberculosis
HIV / AIDS
herpes

Other Conditions
epilepsy
neurological condition : _____
diabetes (type/onset): _____
allergies (to what & reaction): _____
anaphylaxis? ☐ Yes ☐ No
cancer (type/location): _____
skin conditions (what): _____
arthritis (where): _____
is there a family history of arthritis?
☐ Yes ☐ No

Any other medical conditions?
(e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
☐ Yes ☐ No
If so, what: _____

Family Physician: _____
Address : _____

List ALL current medication & condition it treats: _____
_____
_____

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

Surgeries & date: _____
Car Accidents & date: _____
Other Injuries & date: _____

Overall, how is your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Comments:_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, who & reason _____

What is the reason you are seeking massage therapy? Include location of any muscle or joint discomfort.

_____
_____