URBAN THERAPEUTICS

Health History Form

Date: _____

How did you hear about Urban Therapeutics?

☐ **Health Care Professional: Name** _____

☐ **Existing Patient: Name** _____

☐ **Internet Search:** ☐ **Google** ☐ **Bing** ☐ **Yahoo** ☐ **Yelp** **Search Term:** _____

☐ **Other:** _____

Personal Information

Name: First: _____ **Last:** _____ **Date of Birth:** _____ (mm/ dd/ yr)

Phone: Cell: (___)_____-_____ Work: (___) _____-_____ Email:_____

Address: _____ **City:** _____ **Postal Code:**_____

Occupation: _____ **Height:** _____ **Weight:** _____

Reason for Massage Therapy: _____

On a scale of 1 to 10, where 1 is low and 10 is high, what is the usual intensity of your pain/ discomfort? _____

Have you had a massage before? **Yes No** **For relaxation or other reason?** _____

Current Medications: _____

Previous Major Illnesses, Operations: _____

Accidents (please give dates): _____

_____

Other Medical Conditions (e.g. hemophilia, diabetes): _____

Family History (major illnesses, operations): _____

Lifestyle Questions

Energy Level: ◯**High** ◯**Average** ◯**Low**

Do you take vitamins? ◯**Yes** ◯**No** ➔ ➔ ➔ **Type:** _____ **Frequency:** _____

Do you feel stressed? ◯**Yes** ◯**No** ➔ ➔ ➔ **Cause:** _____

Regular Exercise ◯**Yes** ◯**No** ➔ ➔ ➔ **Type:** _____ **Frequency:** _____

Computer Use? ◯**Yes** ◯**No** ➔ ➔ ➔ **How many hours per day?** _____

Please indicate all conditions/ symptoms you are currently experiencing:

Joint/Soft Tissue Discomfort:
- ☐ Head
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper Back
- ☐ Mid Back
- ☐ Lower Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Other: _____

Reproductive:
- ☐ Pregnant: due date: _____
- ☐ Painful Menstruation
- ☐ Irregular Cycle

General Symptoms:
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Sudden Weight Loss/Gain
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis
- ☐ Headaches (Tension)
- ☐ Migraines

Respiratory:
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Pneumonia

Infectious:
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes
- ☐ Cold
- ☐ Flu
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Other: _____

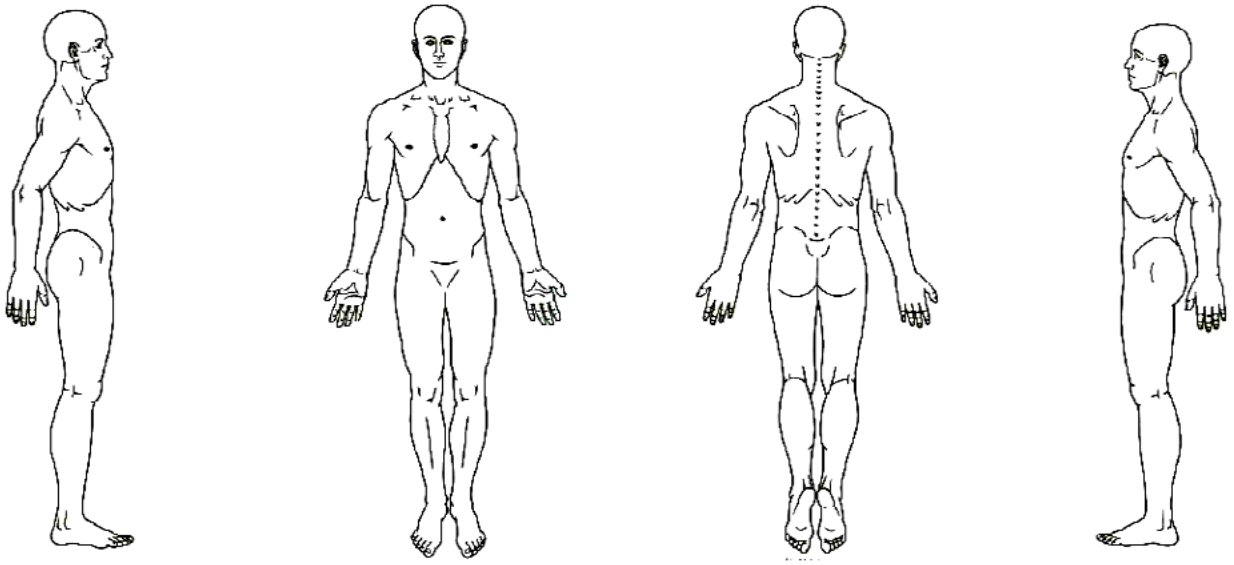
Digestive:
- ☐ Poor Appetite
- ☐ Belching/Gas
- ☐ Constipation
- ☐ Ulcer

Skin:
- ☐ Rashes
- ☐ Itching
- ☐ Bruise Easily

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Coronary Heart Disease
- ☐ Heart Attack
- ☐ Poor Circulation
- ☐ Stroke / CVA
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Swelling of the Ankles

Eye, Ear, Nose, Throat:
- ☐ Allergies
- ☐ Frequent Colds
- ☐ Sinus Infection
- ☐ Swollen Glands
- ☐ Hearing Loss
- ☐ Tinnitus (Ringing in Ears)

Indicate areas of pain/discomfort on diagram



PLEASE READ CAREFULLY AND SIGN

1. I acknowledge that the information I have provided is true to the best of my knowledge and I am responsible to let my therapist know if there are any changes.
2. I understand that my information is confidential and will not be released without my written consent
3. I consent that Joseph Zonys, owner of Urban THerapeutics will retain ownership of patient records.
4. I understand that I am responsible for any charges incurred during the course of my treatments (including unpaid charges from ICBC, Worksafe BC, MSP, my extended health care plan and any third party insurer)
5. I agree to pay the full cost of my appointment if I do not provide 24 hours cancellation notice by phone.
6. I consent to Registered Massage Therapy treatment, assessment and examination

Please confirm that you agree to all of the above. Yes / No

Patients Name / Signature _____ Date _____(M/D/Y)

Guardian Name/ Signature_____ Date_____(M/D/Y)
(If patient under 19 years)