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: _______________

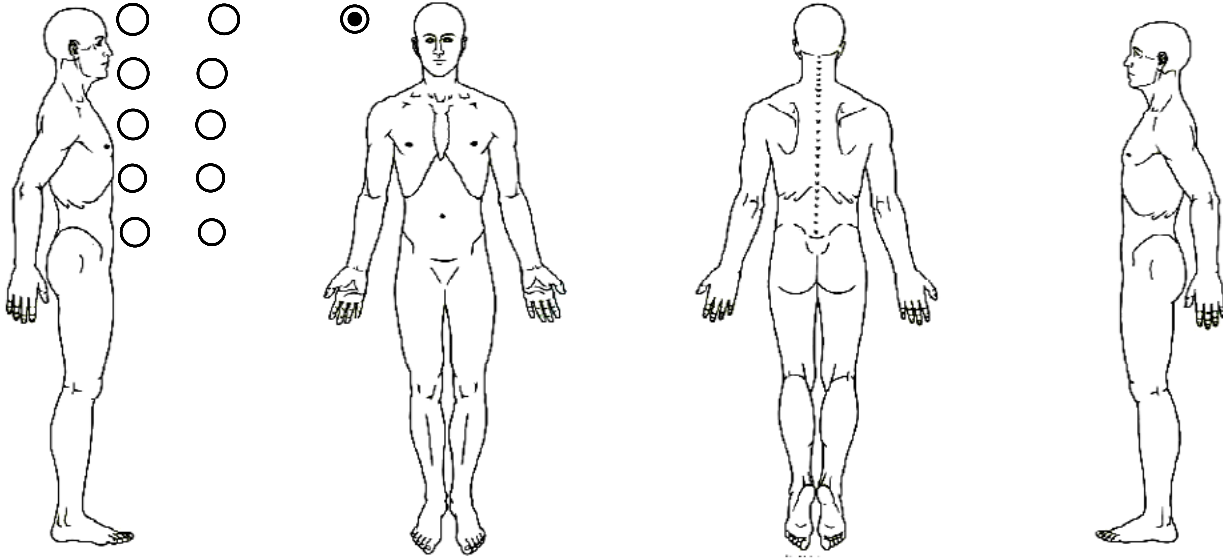
Digestive:
- ☐ Poor Appetite
- ☐ Belching/Gas
- ☐ Constipation
- ☐ Ulcer

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 50% of the cost of my treatment if I cancel with in 24 hours of appointment.
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)