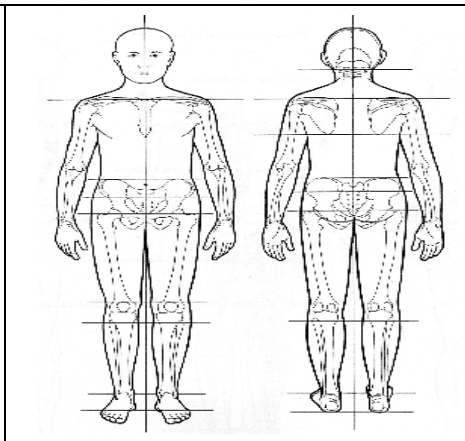
Urban Body – Alicia Wolfe RMT - Confidential Health History & Patient Intake Form

The information provided below will assist us in preparing your treatment plan, please complete this form accurately to help ensure safety. All information provided on this form is kept strictly confidential and can only be released with your written permission or by act of law. Please let us know if you have any questions or concerns.

Today's Date:	☐ **Female** ☐ **Male**	**Occupation:**	
Name:		**Medical Doctor:**	
Address:		**Doctor Phone #**	
City:	**P/C:**	**Extended Health Care Insurance (Check below):**	
Home Ph#	**Cell Ph#**	**Yes** ☐	**No** ☐
Email:		**Benefits Provider:**	
Date of Birth (D/M/Y):		**Policy #**	
Work Related Injury/accident (WSIB): ☐ **Accident Date:**		**Policy Holder Name:**	
Motor Vehicle Accident (MVA): ☐ **Accident Date:**		**Policy Holder Date of Birth:**	
Additional Info:		**Policy Holder Relationship :**	

Reason for Visit:		
Injury Cause:		**Injury Date:**
Associated Symptoms:		
Please mark on the drawing the areas of discomfort & pain you are feeling using the symbols below: **V = Stabbing/Sharp pain** **/ = Aching & Tension** **O = Tingling** **• = Numbness** **X = Burning**		**Aggravating Factors (example: standing or sitting for long periods of time):** **Reliving Factors (what helps decrease your discomfort):**
Please list on a scale of 1 to 10 the severity of your pain in the last 7 days: ***(0 = no pain, 3 = irritating/uncomfortable, 5 = moderate pain, 8 = very painful, 10 = unbearable pain)***		
Previous Treatment/Therapy (please circle below any that apply): **Massage Therapy Chiropractor Physiotherapy Osteopathy Acupuncture Other:**		
Medical History- Please list any major surgeries, operations or procedures (past or future):		

Medical History continued on next page >

Medical History - Continued

Medical Conditions/Diseases

- ○ AIDS/HIV
- ○ Eczema/psoriasis
- ○ Cancer
- ○ Diabetes
- ○ Epilepsy
- ○ Fainting
- ○ Migraines/Headache
- ○ Hepatitis A B C D
- ○ Insomnia
- ○ Lupus
- ○ Polio
- ○ Rheumatic Fever
- ○ Sinus Trouble
- ○ Thyroid Trouble
- ○ Tinnitus
- ○ Tuberculosis TB
- ○ Vertigo

Skin Sensitivity

- ○ Bruise easily
- ○ Rash
- ○ Other Skin Condition

- ○ **Allergies**

- ○ **Contagious Skin Infections (scabies, warts)**

Gastrointestinal

- ○ Abrupt weight loss
- ○ Abrupt weight gain
- ○ Colitis
- ○ Diverticulitis
- ○ GERD/GORD
- ○ Heartburn
- ○ Hepatitis
- ○ Irritable Bowel
- ○ Ulcer

Genitourinary

- ○ Pregnant

Due Date:

- ○ Kidney Trouble
- ○ Prostate Trouble
- ○ Sexual Dysfunction
- ○ STD's

Cardiovascular/Lung

- ○ Anaemia
- ○ Angina
- ○ Asthma
- ○ Bleeding Disorder
- ○ Bronchitis
- ○ COPD
- ○ Heart Attack
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Lung/Breathing Problems
- ○ Mechanical Heart Valve
- ○ Pacemaker
- ○ Shortness of breath
- ○ Stroke/TIA
- ○ Varicose Veins

Please note any family history of conditions:

Musculoskeletal

- ○ Artificial Joint, Pins/Screws
- ○ Bone Fracture
- ○ Dislocated Joint
- ○ Fibromyalgia
- ○ General Stiffness
- ○ Weakness
- ○ Numbness/Tingling
- ○ Osteoarthritis
- ○ Rheumatoid Arthritis
- ○ Multiple Sclerosis
- ○ Spinal Disc Disease
- ○ Other (List below)

Please list any Medications (both prescription & non-prescription) you are taking :

Informed Consent for Massage Therapy (Please read carefully)

I have completed the information accurately and to the best of my knowledge including stating all medical conditions. I will advise of any future health history changes so that my records can be updated accordingly. I consent to a massage as discussed with the RMT and understand that I can request a change in treatment/modify or terminate treatment at any time during the session. I have been informed of the fee schedule as well as the 24 hour cancellation policy for appointments and all associated appointment cancellation fees.

Patient Name (Please Print):_____ Signature:_____ Date:_____

Therapist Signature:_____ Date:_____