Dear Valued Patient,

Thank you for choosing UC Health Integrative Medicine for your Massage Therapy.

To better serve you and all of our patients, we kindly ask that you arrive 15 minutes before your scheduled appointment time to allow for registration and check in and to also bring with you the completed New Patient Intake Questionnaire along with your photo ID and insurance card.

*If you need assistance filling out this form, please contact the office at 513-475-WLNS (9567).*

*If you have any questions, feel free to contact us at 475-WLNS (9567)*

Our aim is to help people feel *truly well*. We look forward to your first visit and partnering with you on your wellness!

-Your Integrative Medicine Care Team
UC Health Integrative Medicine Appointment Policy- 2019

We respect your time. That is why, we have implemented an Appointment Policy to address no shows, cancellations and late arrivals. We hope this policy will help our continued focus on better serving our patients and providing excellent customer service.

1. Arrival Time:
   a. New Patients
      i. New Patients are expected to arrive 15-20 minutes before scheduled appointment time. This allows time for check in and optimizes time with your provider.
   b. Established Patients
      i. All Established Patients are expected to arrive 15 minutes before scheduled appointment time.

   **Please be mindful of your appointment time. Arriving at the exact time of your scheduled appointment causes delays not only, for you but also, for patients being seen after you.**

2. Arriving Late to Appointments:
   a. Patients arriving 15 minutes or later to their scheduled appointment may be asked to reschedule their appointment.

3. Cancellations & Rescheduling of Appointments:
   a. We require 24-hour cancellation or rescheduling notice for all office appointments.
   b. Cancellations less than 24 hours in advance will be considered a “no show”.

4. Dismissal from Practice:
   a. Should a patient late cancel or “no show” their scheduled office appointment 3 times within a rolling 12 month period with any of our UC Health Integrative Medicine providers, it may result in dismissal from the practice.

Patient Name: ______________________________

Patient Signature: ____________________________

Date: _____________________________________

**This policy is subject to change at any time.**
Massage Therapy New Patient Questionnaire

Today’s Date: ________________ Name: _______________________________ D.O.B.: ______________ Age: ______

Address: ______________________________ City: _______________________ State: _____ Zip: _____________

Email: ______________________________ Occupation: __________________ Employer: __________________

Home phone: ______________ Work phone: ______________ Cell: ______________

At what number do you prefer to be contacted?  □ Home  □ Cell  □ Work

Are you new to UC Health?  □ Yes  □ No

How did you learn about UC Health Integrative Medicine?
Referred by: ______________________________  □ Physician Referral  □ Friend/Family  □ Internet  □ Social Media

 □ Flyer/Brochure  □ Insurance Company  □ Website  □ Other: __________________

PRIMARY HEALTH CONCERN:
Please list the primary health concern(s) you hope to address during your visit below and rate your level of pain/discomfort.

<table>
<thead>
<tr>
<th>Primary Complaint</th>
<th>Severity 0-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Complaint</th>
<th>Severity 0-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Complaint</th>
<th>Severity 0-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>
INTEGRATIVE THERAPIES

Please check any integrative therapies that you have tried, if they have helped or not, and if you are currently using them:

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Tried?</th>
<th>Helpful?</th>
<th>Currently Use?</th>
<th>How often?</th>
<th>With whom/where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk therapy/Counseling</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage therapy</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoga</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tai Chi/Qigong</td>
<td>☐</td>
<td>☐ Yes ☐ No</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Integrative Healthcare Providers you are working with: ________________________________________________

DAILY LIVING

Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No
If yes, please explain
__________________________________________________________________________________________________

Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No
If yes, please describe.
__________________________________________________________________________________________________

Do you perform any repetitive movement in work, sports, or hobby? ☐ Yes ☐ No
If yes, please describe
__________________________________________________________________________________________________

Do you use any of the following or regularly apply to your skin:

☐ Lotion   ☐ Oil      ☐ Essential oil  ☐ Cream  ☐ Extract  ☐ Plaster  ☐ Medication
☐ Perfume  ☐ Cologne  ☐ Antiperspirant/deodorant  ☐ Other: ________________________________
Please list ALL product sensitivities and reactions:

<table>
<thead>
<tr>
<th>Name of Product</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

EXERCISE HISTORY

1. How would you rate your overall energy level? **Low** 0 1 2 3 4 5 6 7 8 9 10 **High**
2. How often do you exercise? ☐ No exercise ☐ Once a week ☐ Twice a week ☐ Three times a week or more
3. Work related: ☐ Mainly sitting ☐ Up and down ☐ Mainly active
4. Are you able to perform exercises such as walking 3 blocks, swimming or using exercise bike? ☐ yes ☐ no

Physical Limitations Preventing Exercise: Please circle the appropriate response:

- Hip pain
  - ☐ yes ☐ no
- Knee pain
  - ☐ yes ☐ no
- Ankle pain
  - ☐ yes ☐ no
- Foot pain
  - ☐ yes ☐ no
- Back pain
  - ☐ yes ☐ no
- Fatigue
  - ☐ yes ☐ no
- Diaphoresis (sweating)
  - ☐ yes ☐ no
- Shortness of breath
  - ☐ yes ☐ no

MEDICAL HISTORY

Are you currently under medical supervision? ☐ Yes ☐ No
If yes, please explain

______________________________________________________________________________

Are you currently taking any medication? ☐ Yes ☐ No
If yes, please list

______________________________________________________________________________

Please check any condition listed below that applies to you?

- ( ) contagious skin condition
- ( ) open sores or wounds
- ( ) easy bruising
- ( ) recent accident or injury
- ( ) recent fracture
- ( ) recent surgery
- ( ) artificial joint
- ( ) sprains/strains
- ( ) current fever or in last 24hr
- ( ) swollen glands
- ( ) allergies/sensitivity
- ( ) heart condition
- ( ) high or low blood pressure
- ( ) circulatory disorder
- ( ) varicose veins
- ( ) atherosclerosis
- ( ) Lymphatic conditions
- ( ) deep vein thrombosis/blood clots
- ( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
- ( ) osteoporosis
- ( ) epilepsy
- ( ) headaches/migraines
- ( ) cancer
- ( ) diabetes
- ( ) decreased sensation
- ( ) back/neck problems
- ( ) Fibromyalgia
- ( ) TMJ
- ( ) carpal tunnel syndrome
- ( ) tennis elbow
- ( ) pregnancy if yes, how many months?_________
Please explain any condition that you have marked above

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Do you currently have a fever or have had a fever in the last 24 hours? ☐ Yes ☐ No

Have you been diagnosed with a blood clot(s) ie: DVT, PE in the last month? ☐ Yes ☐ No

Are you currently being monitored for low blood count levels ie: platelets, white blood cells? ☐ Yes ☐ No ☐ Unknown

Please MARK any area that you would like the Massage Therapist to focus on during your session.

Do you have any particular goals in mind for this massage session?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________