UC Health Integrative Medicine

UC Health Garner Neuroscience Institute
3113 Bellevue Ave.
Cincinnati, OH 45213

UC Health Physicians Office South
7675 Wellness Way, 4th Floor
West Chester, OH 45069

UC Health Barrett Cancer Center
234 Goodman Street, 2nd Floor
Cincinnati, OH 45219

P (513) 475-9567
F (513) 458-1989

UCHealth.com/Integrative

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

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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. ***

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UC Gardner Neuroscience Institute
3113 Bellevue Ave; 4th Floor
Cincinnati OH 45219

Barrett Cancer Center
234 Goodman Street 2nd Floor
Cincinnati OH 45219

West Chester Women's Center
7675 Wellness Way; Suite 400
West Chester OH 45069

Phone: (513) 475-WLNS (9567) **Fax:** (513) 475-9231 **Website:** UCHealth.com/Integrative

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.

Primary Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
Secondary Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
Other Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***

INTEGRATIVE THERAPIES

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

Therapy:	Tried?	Helpful?	Currently Use?	How often?	With whom/where?
Physical therapy	☐	☐Yes ☐No	☐	___________	______________________
Talk therapy/Counseling	☐	☐Yes ☐No	☐	___________	______________________
Massage therapy	☐	☐Yes ☐No	☐	___________	______________________
Yoga	☐	☐Yes ☐No	☐	___________	______________________
Chiropractic	☐	☐Yes ☐No	☐	___________	______________________
Acupuncture	☐	☐Yes ☐No	☐	___________	______________________
Meditation	☐	☐Yes ☐No	☐	___________	______________________
Tai Chi/Qigong	☐	☐Yes ☐No	☐	___________	______________________

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:

Name of Product:	**Reaction?**
____________________	____
____________________	____
____________________	____

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	Back pain	☐ yes	☐ no
Knee pain	☐ yes	☐ no	Fatigue	☐ yes	☐ no
Ankle pain	☐ yes	☐ no	Diaphoresis (sweating)	☐ yes	☐ no
Foot pain	☐ 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

____

____

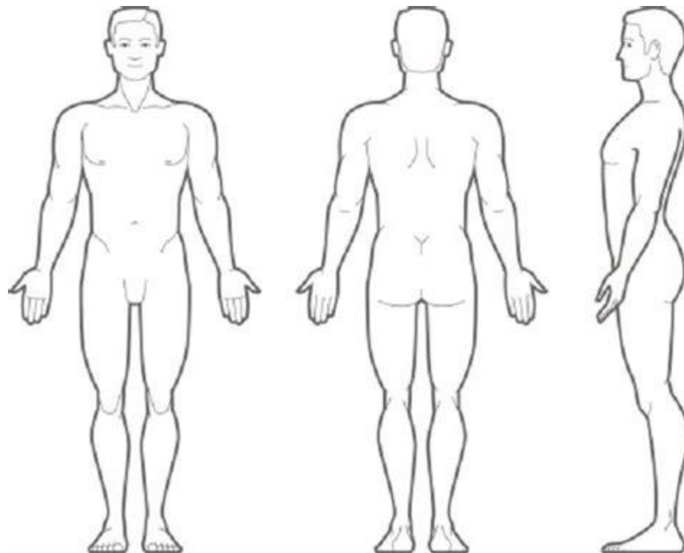
____

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?

____

____

____