Urban Healing Arts Studio
Confidential Personal Health Information

Personal Information How did you hear about us: _____

Name _____

Address _____ Home_____

City _____ State _____ Zip _____ Work _____

Birthday _____ Occupation _____

Email Address _____

☐ Check to receive newsletters and specials. We never share or sell your email address.

Emergency Contact _____ Phone _____

Primary Physician _____ Phone _____

METHOD OF PAYMENT

☐ Personal ☐ Gift Card ☐ Other _____

MASSAGE HISTORY & TREATMENT INFORMATION

Have you ever received a massage before? ☐ yes ☐ no

If yes, frequency and type: _____ Date of last massage: _____

Are you currently seeing a medical practitioner (MD, Chiropractor, Physical Therapist etc.)? ☐ yes ☐ no

If yes, please explain: _____

_____

List stress reduction/exercise activities (include frequency): _____

_____

List current medications (include ibuprofen, aspirin etc.) Give dosage & condition: _____

_____

Surgeries: _____

_____

Accidents (automobile, falls etc.): _____

_____

Allergies (food, medications, drugs, chemicals): _____

_____

Reason for today's visit? Main problem(s) that you want to focus on? _____

_____

How long have you been experiencing symptoms/problems associated with this issue? _____

Have you received a diagnosis from a physician? Yes___ No___ If so, what is your diagnosis?_____

_____

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ILLNESSES/PATHOLOGIES/CONDITIONS

Please mark any categories in which you have had or currently have. Please briefly describe each condition that is marked. Please also indicate which side of body when applicable.

Skin
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes/cold sores
- ☐ Allergies
- ☐ Other_____

Circulatory
- ☐ High/low blood pressure
- ☐ Heart Problems
- ☐ Phlebitis/varicose veins
- ☐ Blood clots
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Stroke
- ☐ Poor circulation
- ☐ Other_____

Habits
- ☐ Coffee
- ☐ Tobacco
- ☐ Alcohol
- ☐ Drugs

Muscle Joints
- ☐ Arthritis
- ☐ Joint or bone disease
- ☐ Tendonitis/Bursitis
- ☐ Sprains/strains
- ☐ Osteoporosis
- ☐ Neck/shoulder/arm pain
- ☐ Low back/hip/leg pain
- ☐ Spasms/cramps
- ☐ Jaw pain/TMJ
- ☐ Lupus
- ☐ Other_____

Other
- ☐ Sleep disorder
- ☐ Chronic pain
- ☐ Chronic fatigue
- ☐ Migraines/headaches
- ☐ Anxiety/stress disorders
- ☐ Cancer/tumors

Nervous System
- ☐ Pinched Nerve
- ☐ Numbness/tingling
- ☐ Sciatica/shooting pain
- ☐ Other_____

Digestive
- ☐ Gas/bloating
- ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers
- ☐ Other_____

Reproductive
- ☐ Ovarian/menstrual problem
- ☐ PMS
- ☐ Pregnant
  How many weeks? _____
- ☐ Prostate problems
- ☐ Other_____

Additional Comments: _____

_____

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.

I have stated all known medical conditions and will update the massage practitioner in writing of any changes in my health status if necessary.

Signed: _____ **Date:** _____

(Patient or responsible party)

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Notice of Privacy Practices

Urban Healing Arts Studio, LLC, is a provider of medical services, and as such, we are required to maintain and keep records regarding your massage treatments confidential, secure, and accessible only to those persons with legal right to view them. Our confidentiality and privacy practices are as follows:

Use and Disclosure of Records

Our policy is to maintain your privacy and confidentiality regarding all medical records pertaining to your treatment at Urban Healing Arts Studio. To ensure your privacy, we do the following:

We store all of your records in a locked file, and only remove them when they are in use, then return them immediately after use.

We do not disclose, publish, or share your confidential records with any third party without your written authorization, except when required to do so by law, such as a court-ordered subpoena. If your treatment is covered by insurance or worker's compensation, we may also be required to submit your treatment records to your insurance provider.

We do not currently store, fax, email, or otherwise transfer your confidential records electronically. If, in the future, we begin to store or transfer confidential health records, we will only do so in strict compliance with the law, meaning that all documents will be encrypted at all times and all electronic storage devices or computers in our control will be strictly accounted for and kept secure in accordance with the law.

Client Rights

You, the client, have the right to review, correct, or obtain copies of your records at any time upon written request. You may come to our office during normal business hours to review your records by submitting a written request. Access will be granted by appointment within 15 days of your request. Or, you may request in writing that we mail you a copy of your records for a nominal fee.

To request copies contact:

20011 Ballinger Way NE
Suite 206
Shoreline, WA 98155

888-718-7226
palesteen@urbanhealingarts.com

I, (please print) _____ have received, read and understand this privacy policy as it relates to receiving massage from Urban Healing Arts, LLC

Signature _____ Date _____