UNITY
BODYWORKS

This health history intake form is designed to give your therapist a clear understanding of your health and lifestyle. The information you provide will help us to create an effective treatment plan.

Today's Date:_____MSP#:_____

Name_____ Date of Birth_____

Address_____ Postal Code_____

Phone (H) _____ (W) _____ Email_____

Occupation_____

Whom may we thank for your referral?

_____

Please list your health care practitioners and their titles:

_____

_____

_____

Why are you seeking treatment? **Describe symptoms, pain and duration.**

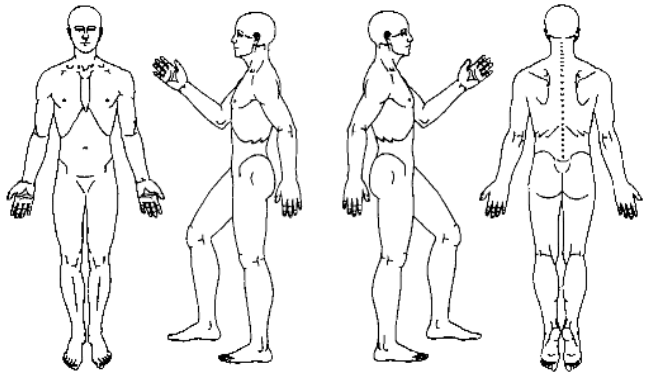
_____

_____

_____

_____

_____



Please circle on the diagram areas that are currently seeking help for.

Please turn over (more information on back)

Do any of the following conditions apply to you? (please check)

( )	headaches	( )	skin conditions
( )	chronic muscle pain	( )	cancer
( )	shooting/radiating pain	( )	diabetes
( )	joint pain/stiffness	( )	digestive disorders
( )	arthritis/degenerative disk	( )	hyper/hypo thyroid
( )	osteoporosis	( )	fatigue
( )	bruise easily	( )	depression
( )	varicose veins	( )	dizziness/vertigo
( )	high/low blood pressure	( )	pregnancy
( )	high cholesterol/heart disease	( )	PMS symptoms
( )	stroke (CVA)	( )	menopause
( )	nervous system disorders	( )	respiratory ailments

Please list any other conditions not listed above:

How would you describe your stress level?

What type of physical activities are you involved in? How often do you exercise?

Are there any health or fitness goals you would like to pursue at this time?

How would you rate your energy level?

How do you sleep?

Please list all medications you are taking (including ibuprofen or aspirin):

Please list any vitamins or supplements you are taking:

Please list all injuries you have sustained, even if it appears unrelated to your current condition (i.e. previous surgeries):

If you are comfortable sharing with your therapist, have you experienced any significant emotional trauma in your life? This information may be helpful to identify how these experiences could be held in a negative way in your body.

UNITY
BODYWORKS

Client Responsibilities

Please allow 24 hours notice if you must cancel an appointment. You may be charged the entire cost of the appointment if adequate notice is not given, or if you miss your appointment.

It is sometimes helpful to collaborate with your other health care providers. **Do you give your therapist permission to share your treatment information with another practitioner?** This will be discussed with you beforehand. (please circle)

Yes No

This information is confidential and will only be used to develop a best possible treatment for your specific pattern / needs. If following your treatments, you think of other symptoms that may be relevant to your health patterns, please let us know. Thank you.

Read and understood by: _____Date: _____
(your signature)

Notes: *(For Practioner Use Only)*

ICBC CLAIM #_____

WCB CLAIM #_____