

Therapist name: _____

Your name: _____

Medical history

Do you have any medical conditions?

☐ Yes ☐ No If yes, please explain: _____

Are you currently taking any medication?

☐ Yes ☐ No If yes, please list details: _____

Do you have any allergies?

☐ Yes ☐ No If yes, please share more details: _____

Have you had any recent surgeries or injuries?

☐ Yes ☐ No If yes, please explain: _____

Is there a specific area of the body where you are experiencing tension, stiffness, or discomfort?

☐ Yes ☐ No If yes, please explain: _____

Do you have any of the following conditions? (Check all that apply)

- ☐ Heart condition ☐ High/low blood pressure ☐ Diabetes
☐ Skin conditions ☐ Cancer ☐ Epilepsy ☐ Immunodeficiency
☐ Other: _____

Are you currently pregnant?

☐

Yes

☐

No

If yes, how many weeks?

Add-on services (if applicable)

Cupping: Cupping may leave marks for several days.

☐

Acknowledged

Reflexology: Have you had reflexology before?

☐

Yes

☐

No

Consent & waiver

I understand this injury pain management treatment is intended for general well-being, is not a substitute for medical care, and is strictly non-sexual. I agree to notify the therapist of any health changes that may affect my treatment. Urban's role is to connect me with an independent therapist, and my contract is directly with them. I release Urban and the therapist from liability related to this session.

Date:

Client signature:
