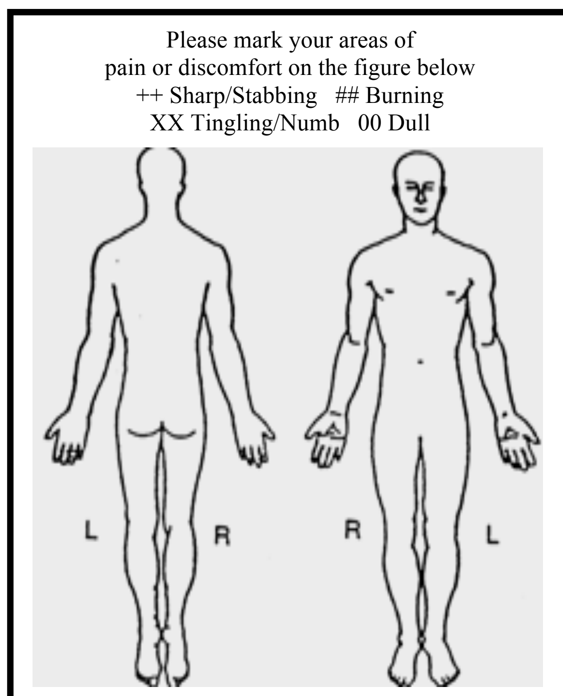
CONFIDENTIAL PATIENT INFORMATION MASSAGE

Name____ Date _____________________________________
Home Ph.______________________________________ Cell Ph._____________________________________
Address ______________________________ City _______________State _____ Zip __________ Sex M F
Age __________ Birth Date____________________ Marital Status M S W D How many children? ____________
Occupation_____________________________ Employer__________________ Office Ph. ____________________
Work Address____ Email Address__________________________
Name of Spouse ____________________ Occupation ____________________ Employer____________________
Who may we thank for referring you? ____
Have you previously had professional massage? ☐ Yes ☐ No If so, when and how often_______________________
Have you previously had chiropractic care? Yes No If so, who was the doctor and when?__________________________
Would you like to receive ☐ Email Reminders ☐ Text Reminders, Cellular Carrier: ___________________________
Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.):
1. ____ Date: __________________________________
2. ____ Date: __________________________________
3. ____ Date: __________________________________

AREAS OF COMPLAINT

Please mark your areas of
pain or discomfort on the figure below
++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Medication: Please list all medications you are currently taking. We offer information on what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your therapist.

1. ____________________ 3. ____________________ 5. ____________________ 7. ___________________
2. ____________________ 4. ____________________ 6. ____________________ 8. ___________________

Nutrients: Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

1. ____________________ 3. ____________________ 5. ____________________ 7. ___________________
2. ____________________ 4. ____________________ 6. ____________________ 8. ___________________

General Medical Information:

1. Y N Do you suffer from back pain? If so, upper, mid, lower back? ________________________________

2. Y N Do you suffer from headaches? If so, how often? ____

3. Y N Do you have any allergies (medications, ointments, oils, etc)? If yes, please explain.

____

4. Are you wearing: _____ contact lenses? _____ hearing aid? _____ hair piece?

5. Check the conditions that have affected your health in the past 2 years.

_____ arthritis
_____ asthma/allergies
_____ athletes foot
_____ blood clots
_____ broken/dislocated bones
_____ bruise easily
_____ cancer
_____ chronic pain
_____ chronic fatigue syndrome
_____ circulatory problems
_____ constipation/diarrhea
_____ depression/anxiety
_____ diabetes
_____ digestive problems
_____ diverticulitis
_____ fatigue
_____ fevers
_____ fibromyalgia
_____ heart disease
_____ hepatitis
_____ high blood pressure
_____ infectious diseases
_____ jaw pain or TMJ disorder
_____ joint pain
_____ muscle sprain/strain
_____ scoliosis
_____ seizures/epilepsy
_____ skin conditions
_____ sleep difficulties
_____ stroke
_____ sinus problems
_____ varicose veins
_____ whiplash

6. Y N Do you have any other medical conditions or injuries? _______________________________________

____

____

Diet/Lifestyle:

1. How much water do you drink a day? ___8-oz. glasses. What kind? Tap Filtered Distilled
2. How many times do you eat fast food each week? ________________
3. What are your health goals for the upcoming 6 months? ____
4. Do you have any food allergies? If yes, please name: ____
5. On a scale of 1 to 10, what level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10
6. On a scale of 1 to 10, what is your commitment to making a lifestyle improvement? 1 2 3 4 5 6 7 8 9 10

Female Only:

Is there any chance you are pregnant? _____ Yes _____ No If yes, how many weeks? ______________

Name: ________________________________ Signature: ___________________________ Date: ___________

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, ________________________ , hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practices has the right to refuse to treat me.

____ 7.I understand that a 24-hour notice for cancellation for massage therapy appointments is required to avoid incurring a cancellation charge equal to 50% of the cost of the service I was scheduled for. In the event that I do not give the required notice, I will be responsible for payment for the missed appointment.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Print Name:________________________________ Sign:__________________________________ Date:______________________

TERMS OF ACCEPTANCE

Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band. In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible. Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

_____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

_____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort.

_____ I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____ I affirm that I have notified my therapist of all known medical conditions and injuries.

_____ I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

I have read and understand the information above.

Print Name:________________________________ Sign:__________________________________ Date:______________________