Power Source
Express Life More Fully

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1422 Monterey Street, Ste. A-201 • San Luis Obispo, CA 93401 • Phone (805) 781-9155 • www.powersourcechiro.com

Name _____ Phone: Day_____ Eve:_____

Address _____ ZIP_____ Occupation_____

Email_____ DOB_____ Referred by _____

Demographics: Preferred Language: _____ Race: _____ Ethnicity: Hispanic Non-Hispanic

Medications:_____ Medication Allergies:_____

Smoking status: Current-every day Current-some days Former smoker Never Smoker

Have you ever had a massage?_____ When was your last massage? _____

Primary Complaint: _____ How long have you noticed this? _____

Please mark the most accurate answer:

Are you Right or Left handed? R L Current Height:_____ Weight:_____ Blood Pressure: _____

Do you exercise? Daily Moderate None Do you stretch? Daily Moderate None

Please check if you have or had had any of the following:

Severe or Frequent Headaches	Congenital Heart Defect	Shingles
Hepatitis	Heart Surgery/Pacemaker	Cancer
Dizziness	Anemia	Loss of Sleep
Kidney Problems	Diabetes	HIV/AIDS
Heart Murmur	Chemotherapy	Thyroid
Numbness or Pain	Low Back Pain	Jaw Pain
in Arms/Legs/Hands	Frequent Neck Pain	Asthma
Digestive Problems	Herniated Disk	Arthritis
Difficulty Breathing	Ulcers	Stress
Heart Attack/Stroke	Swelling	Skin Disorders (i.e. Athletes Foot)
Pain Between Shoulders	Sinus Problems	High/Low Blood Pressure
Back Pain ___Low ___Mid____Upper		

Are you pregnant or is there any chance of pregnancy? Yes No I don't know
Are you under a physician's care? Yes No If Yes, who is your Dr.? _____
Please list your medications: _____
Please list any Medication Allergies: _____
Pressure: Which do you prefer? Light Medium Medium-Deep Deep I Don't know
Are there any areas that are particularly sensitive or ticklish? If so, please indicate: _____
What results would you like from this massage? _____
_____
Depending on necessity of use, would you like me to use essential oils and/or deep heating lotion to aid in the therapeutic process? Yes No

Please check the areas that you give consent to receive massage:

ALL AREAS INDICATED BELOW:
Face Hips Arms Feet Glutes Legs Shoulders Hands Neck Back

I understand that this is my choice to receive Massage Therapy. I understand that Massage Therapy is non-sexual Therapeutic Massage given with the aim to reduce stress and for the relief of minor tension, pain or spasm. To the best of my knowledge, I have provided accurate information concerning my personal health. Massage Therapists do not diagnose or treat medical conditions. Any health concerns should be brought to the attention of your health care provider. I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

Signature_____ Date_____

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Muscle Therapy Policies

The following are our policies regarding our muscle therapy or trigger point therapy services:

Appointment times are specific: Your time starts at the appointed time and thus ends in the allotted time frame. If you arrive late, you will have a shorter massage for the same fee. It is important that you understand that the time for your muscle therapy session includes the following:

1. Time to undress and dress: approximately 2 to 3 minutes total.
2. Consultation: Initial session 5 minutes, subsequent sessions 2 to 3 minutes each.
3. Explanation of home stretching or therapy: 2 to 3 minutes as needed.

24 hour cancellation policy: We require a 24 hour notice for cancellation or reschedules. If you cancel within 24 hours you will be responsible for a $15 administration fee; *however* you will be financially responsible for your *entire* appointment if you do not show to your appointment or cancel within 2 hours of your appointment. We will not bill your insurance for this fee.

Treatment attire and personal conduct: Each treatment varies, but please arrive clean, and in comfortable clothing for your muscle therapy session. Because muscle therapy can release toxins into the body, no alcohol or illicit drug consumption before your session will be tolerated, and your therapist reserves the right to re-schedule your appointment for another date. This is for your safety, as well as the therapist's.

Payment is due at the time of service: Powersource Chiropractic is only legally allowed to offer you a Pay at the Time of Service Discount if payment is received at the time of service. If payment is delayed to a later time you will be responsible for our Minimum Bill Fee. If you have insurance that will cover Muscle Therapy services then your co-payment is due at the time of service. *(Please reference Powersource Chiropractic Minimum Bill/Charge Fees)*

Please sign your name below indicating that you have read, understand and abide by the above policies.

_____ _____

Print Name ***Date***

_____ _____

Signature ***Witness***

POWERSOURCE CHIROPRACTIC
1422 MONTEREY ST STE A-201
SAN LUIS OBISPO, CA 93401
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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth:_____

I have received Powersource Chiropractic's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that is practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use to disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Due to its participation in the Electronic Health Records Stimulus Program and the requirements of the HI-TECH act, Powersource Chiropractic is required to provide to me a Clinical Summary report after every visit. However, due to the nature and frequency of chiropractic care, these summaries are often blank. My signature below indicates my wish to *decline* receipt of my Clinical Summary on each visit. Should I require a copy of my treatment notes for any given appointment, I understand that this clinic is required to provide me this information within 4 business days of my request.

Patient Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient: _____