PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: ______________________ Date: __________ Referred by: __________

Address: ______________________ Phone - Day: __________

City/State/Zip: ______________________ Phone - Eve: __________

Birthday: __________ SS# __________ Occupation/Employer: __________

Primary Health Care Provider: ______________________ Phone: __________

Permission to consult with primary provider? Please initial if yes. ☐ Yes __________ ☐ No

Emergency contact: ______________________ Phone: __________

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency __________ Date of last massage __________

What results do you want from your massage sessions? ______________________

Prioritize the areas of your body that you would prefer to be massaged. ______________________

Are there any areas of your body that you prefer not be massaged? ______________________

Are you currently seeing a medical practitioner? Please explain if yes. ☐ Yes ☐ No ______________________

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if yes. ☐ Yes ☐ No ______________________

List stress reduction and exercise activities. Include frequency. ______________________

List current medications, including aspirin, ibuprofen, etc. ______________________

PREVIOUS HISTORY

(Include year and treatment received)

Surgeries: ______________________

Accidents: ______________________

HEALTH HISTORY

MUSCULO-SKELETAL

- ____ bone or joint disease ____
- ____ tendonitis ____
- ____ bursitis ____
- ____ broken/fractured bones ____
- ____ arthritis ____
- ____ sprains/strains ____
- ____ low back, hip, leg pain ____
- ____ neck, shoulder, arm pain ____
- ____ headaches/head injuries ____
- ____ spasms/cramps ____
- ____ jaw pain/TMJ ____
- ____ lupus ____
- ____ other ____

CIRCULATORY

- ____ heart condition ____
- ____ varicose veins ____
- ____ blood clots ____
- ____ high blood pressure ____
- ____ low blood pressure ____
- ____ lymphedema ____
- ____ breathing difficulty ____
- ____ sinus problems ____
- ____ allergies ____
- ____ other ____

INFECTIOUS DISEASE

- ____ disease name(s): ____

____

____

SKIN

- ____ allergies ____
- ____ rashes ____
- ____ athletes foot ____
- ____ warts ____
- ____ other ____

DIGESTIVE

- ____ constipation ____
- ____ gas/bloating ____
- ____ diverticulitis ____
- ____ irritable bowel syndrome ____
- ____ other ____

NERVOUS SYSTEM

- ____ herpes/shingles ____
- ____ numbness/tingling ____
- ____ chronic pain ____
- ____ fatigue ____
- ____ sleep disorders ____
- ____ other ____

REPRODUCTIVE

- ____ pregnant? Stage ____
- ____ PMS ____
- ____ other ____

OTHER

- ____ cancer/tumors ____
- ____ diabetes ____
- ____ eating disorders ____
- ____ depression ____
- ____ drug/alcohol addiction ____
- ____ nicotine/caffeine addiction ____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust 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 medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: ____ DATE: ____

EVALUATION

HISTORY

Name____ Date_______________________________

Age____ Dominant Hand____ Occupation____
Main Activities____
Sporting Activities____

Activity Level (*circle one*): High - Medium - Low
Type of Problem (*circle one*): Acute Trauma - Chronic Trauma - Acute Exacerbation of Chronic Problem

Cause of Problem____
____
____

Symptoms of Pain or Discomfort

When did symptoms begin (date)?____________________ Have you had these before? ___Yes ___No

How often do you have pain? ____

Pain is interfering with: ___Work ___Sleep ___Daily Routine ___Recreation ___Other__________

Activities difficult/painful to perform:
___Walking
___Sitting
___Bending
___Lying Down
___Twisting

Type of pain: ___Sharp ___Dull
___Throbbing ___Aching
___Burning ___Tingling
___Numbness ___Cramping
___Stiffness ___Swelling
___Other________________

Personal Habits

	Heavy	Moderate	Light	None
Water	____	____	____	____
Coffee	____	____	____	____
Tea	____	____	____	____
Soft Drinks	____	____	____	____
Dairy	____	____	____	____
Tobacco	____	____	____	____
Alcohol	____	____	____	____
Sugar	____	____	____	____
Exercise	____	____	____	____

Please list and date major illnesses, surgeries, hospitalizations, or falls causing injury:

___

___

___

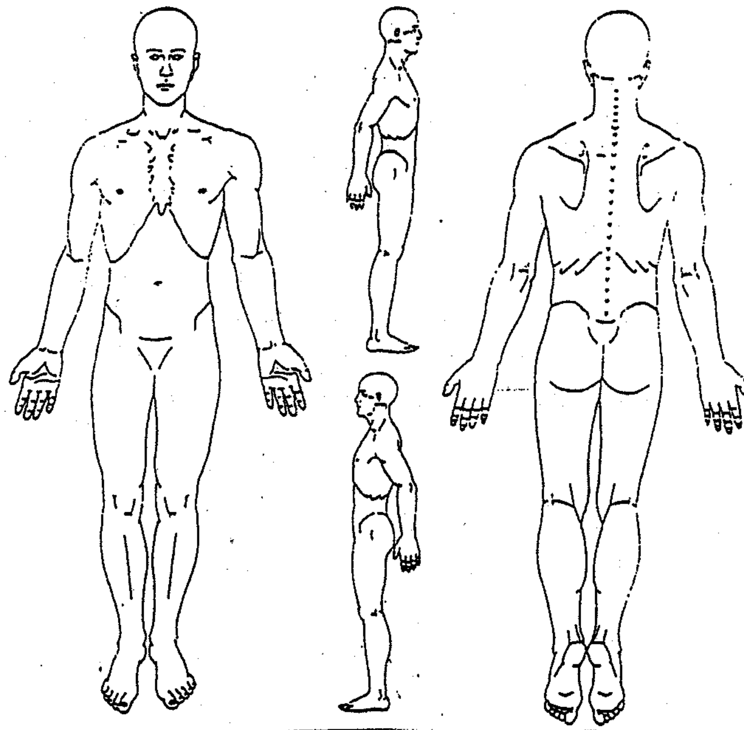
___

Please list any past injury still affecting you:

___

___

Mark on figures the location of any symptoms (pain, tightness/stiffness/tension in muscles or joints; scars, swelling, spasms, etc.)



For Therapist use only:

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MASSAGE THERAPY INSURANCE AND ATTORNEY INFORMATION

Client's Name ____

Private Medical/Health Insurance

Name of insurance company ______________________ Phone # ____________

Subscriber's name __________________ ID# ____________ Group # ________

Subscriber's date of birth ___________ Subscriber's employer ____________________

Covering Auto or Personal Injury Insurance (if applicable)

Name of insurance company ______________________ Phone # ____________

Address ____

Adjuster's name ____________________ Name of insured ____________________

Date of accident __________________ Claim number ______________________

Work Accident Insurance (if applicable)

Employer's complete name ____

Address __________________________________ Phone # ____________

Did you fill out an accident report? Yes ( ) No ( )

Employer's workman's compensation insurance company ____________________________

Address __________________________________ Phone # ____________

Date of Injury __________________ Claim number ______________________

Attorney's Name and Address (if applicable)

Name ___________________________ Firm ______________________

Address ___________________________ Phone ______________________

I hereby give my permission to my licensed massage practitioner(s) (LMP's) to release any information requested by the insurance company, doctor or my lawyer acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to my LMP(s). I am financially responsible for non-covered services.

Client's Signature ___________________________________ Date ____________

Client (or parent/guardian)

MASSAGE THERAPY POLICIES:

Welcome to our clinic. The following is an explanation of our policies. We believe that a clear understanding will allow us both to concentrate on the most important issue: *Regaining and maintaining your health.* We are happy to answer any questions that you may have, and are grateful to be in your service.

1. **When you are scheduled, a specific amount of time is set aside to meet your needs. We do not double book appointments and are not able to place another client in your space without prior notice. Therefore when you are scheduled, it is important that you attend your appointment, and arrive on time.**
2. **If for any reason you are unable to keep your appointment, cancellation notice is required 24 hours prior to your appointment.**
3. **In the event that the above courtesy is not given, a $25.00 "No Show" fee will be charged to the client, and must be paid before the client can continue treatment.**
4. **Charges for services:**
   - **Wellness/ Relaxation Massage paid at time of service:**
     - **30 Minutes = $40.00**
     - **60 Minutes = $70.00**
     - **1.5 Hours = $105.00**
     - **2 Hours = $140.00**
   - **Injury treatment to be billed:**
     - **Each 15 minute unit = $30.00**
     - **4 Units (1 Hour) = $120.00**
5. **Insurance clients: Understand and agree that policies are an arrangement between carrier and client. Insurance will be verified and billed, however, client understands that he or she is responsible for treatment received with is not covered by the insurance contract. In the event that insurance does not pay, and the client becomes responsible for the full payment of services, a 12% annualized interest rate may be charged on the balance remaining after 60 days.**

CLIENT AGREEMENT:

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, or pain, or for increasing circulation and energy flow. I agree to communicate with my practitioner any time I feel like my well-being is compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust 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 medical conditions that I am aware of and will update the massage practitioner of any changes in my health status. My signature indicates that I have read and agree to abide by this policy.

SIGNATURE:______________________________ DATE:__________________

Client (or parent/guardian)

Revised Sept. 14, 2011

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

MASSAGE THERAPY AT
CHIROPRACTIC HEALTH CENTER
127 AVE. C
SNOHOMISH, WA 98290
(360) 568-4185

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ______________________________________

Signature ____

Date ____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in the acknowledgement on this Notice Of Privacy Practices Acknowledgement, but wa unable to do so as documented below:

Date:______________ **Initials**_____________________

Reason:____