MASSAGE INTAKE & HISTORY

HOUSE FAMILY CHIROPRACTIC

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age ____ Birthday _____
Social Security Number _____
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered

Employer/School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you? _____

Primary Care Physician: _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had

❑ Headaches, migraines
❑ Vision problems, contact lenses
❑ Hearing problems, deafness
❑ Injuries to face or head
❑ Sinus problems
❑ Dental bridges, braces
❑ Jaw pain, TMJ problems
❑ Asthma or lung conditions
❑ Constipation, diarrhea
❑ Hernia
❑ Birth control, IUD
❑ Abdominal or digestive problems
❑ Chronic pain
❑ Muscle or joint pain
❑ Muscle, bone injuries
❑ Numbness or tightening
❑ Sprains, strains
❑ Arthritis, tendonitis
❑ Caner, tumors
❑ Spinal column disorders
❑ Diabetes
❑ Pregnancy
❑ Heart, circulatory
❑ Fatigue
❑ Tension, stress
❑ Depression
❑ Sleep difficulties
❑ Allergies, sensitivities
❑ Athletes foot
❑ Infectious diseases
❑ Blood clots
❑ Varicose veins
❑ High/low blood pressure
❑ Rashes, athletes foot
❑ Other _____
_____
_____

Explain any areas noted above _____
Surgeries _____
Accidents _____
Please list all forms and frequency of stress reduction activities, hobbies, exercise _____
_____
Previous massage experience _____
Primary reason for appointment/areas of pain or tension _____
_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES	MEDICATIONS/DOSAGE/FREQUENCY	SUPPLEMENTS

ELECTRONIC HEALTH RECORDS INTAKE

In compliance with requirements for the government EHR program

Race: (circle) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity: (circle) Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer Preferred Language: _____
Smoking Status: (circle) Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

❑ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of massage care.)

Patient Signature: _____ Date: _____

AUTHORIZATION FOR CARE

I hereby authorize the Certified Massage Therapist to work with my condition through the use of massage, as he/she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Certified Massage Therapist will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

SIGNATURE: DATE:

GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE: DATE

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ HEALTH INSURANCE

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), 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 with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT): RELATIONSHIP TO PATIENT:

SIGNATURE: DATE:

MASSAGE CANCELLATION POLICY

A $25 cash fee will be incurred for any massages missed or canceled with less than a 24 hour notice.

PATIENT NAME (PLEASE PRINT):

SIGNATURE: DATE: