CARNES CHIROPRACTIC & WELLNESS CENTER
2323 W. MAIN STREET
SUITE 109
DOTHAN, AL 36301

MASSAGE THERAPY INTAKE FORM

Date: _____

Personal Data: DOB: _____ Referred by: _____

NAME: _____

ADDRESS: _____

_____

_____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Occupation: _____

Primary Health Care Provider: _____ (If none, leave blank.)

*Permission to consult with Primary Health Care Provider?: Initial here for **YES:** _____
Initial here for **NO:** _____

Emergency Contact: Name: _____ Phone: _____

Massage History/Treatment:

Have you ever received a massage? (Circle one) YES NO

If yes, frequency? (Circle one) Yearly Monthly Bi-monthly Weekly

Date of last massage:

What results do you desire from professional therapeutic massage? (Pain relief, tension/stress relief, relaxation, etc.): _____

_____

_____

_____

_____

Prioritize the areas that you prefer to be massaged:

***CONTINUE ON BACK**

CLIENT INTAKE FORM

Are you currently under the care of a general/specialized medical practitioner? Circle one: YES NO

List Stress reduction and exercise activities. Include Frequency:

_____
_____
_____

List current medications **and include aspirin, ibuprofen, herbs and vitamins**:

_____
_____
_____
_____
_____

Medical History:
(Include year and treatment received.)

Medical Conditions:

_____
_____
_____
_____

Surgeries & Accidents:

_____
_____
_____
_____

Instructions: Please note all conditions that apply now. Put (**C) for current** and **(P) for past conditions**.

General

__ Vision problems, contacts
__ Hearing problems, deafness
__ Sinus problems
__ Diabetes
__ Asthma or Lung condition
__ Breast Implants
__ Dental Bridges

Nervous System

__ Fatigue
__ Tension, stress
__ Numbness/Tingling
__ Depression
__ Sleep Difficulties
__ Chronic Pain

Digestive

__ Constipation
__ IBS/Irritable Bowel Syndrome
__ Hernia

Reproductive

__ Pregnancy
__ Hormone Replacement
__ PMS

Circulatory

__ Heart, Circulatory Problems
__ Blood clots
__ Headaches, migraines
__ Varicose Veins

Skin

__ Allergies
__ Warts/Herpes
__ Rashes
__ Athlete's Foot
__ Fungus
__ Psoriasis
__ Poison Oak/Ivy

Musculoskeletal

__ Injuries to face or head
__ Jaw Pain/TMJ
__ Spasms/Cramps
__ Broken Bone
__ Cancer, tumor

__Muscle, bone injuries
__ Sprains, strains
Where:_____
__ Arthritis, tendonitis, bursitis (circle)

__ Back, leg, hip pain (circle)
__Arm, Shoulder, neck pain (circle)

OTHER:

Please read carefully and sign below:

It is my choice to receive a massage. I understand that the treatment is being given for the well being of my body and mind. Because **massage therapy should not be preformed under certain medical conditions**, I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand massage therapy services are designed to be a health aide and do not, in anyway, take place of a doctor's care. I agree to hold harmless the LMT, the staff, and the center for any and all injuries that may occur at the center**.**

Signature:_____ **Date:**_____

PAIN RATING SCALE

How is your pain today?

Please circle the face that most compares to your pain today.

OR

Please circle the number that represents your pain today.

CARNES CHIROPRACTIC CLINIC, LLC.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purposes of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

NAMES OF PEOPLE YOU MAY RELEASE MY HEALTH INFORMATION TO:

_____ Relation_____ Phone_____
_____ Relation_____ Phone_____
_____ Relation_____ Phone_____
_____ Relation_____ Phone_____
_____ Relation_____ Phone_____

PLEASE CHECK ANY/ALL OF THE FOLLOWING WAYS WE ARE PERMITTED TO LEAVE PATIENT INFORMATION FOR YOU:

- o Information regarding my treatment may be left on my ___home phone ___work phone ___cell ___other
- o Information regarding appointments may be left on my ___home phone ___work phone ___cell ___other
- o I do not wish for any of my private information to be left on my home, work, cell or other phone

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____
Name of Patient Date

Carnes Chiropractic & Wellness Center, LLC

Bob Carnes, D.C.

2323 W Main St., Ste. 109 Dothan, AL 36301

(334) 794-2225
(334) 794-0576 fax

Electronic Health Records Stage 2

In compliance with Medicare requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Phone /Text
If text please list cellphone carrier_____
PLEASE NOTE – It is the policy of this office to make reminder call to our patients for appointments so you may receive a reminder text and a reminder call for your appointments.

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	**Father**	**Mother**	**Sibling: Circle One brother/sister**	**Offspring: Circle One Son/daughter**
Example: Heart Disease		***X***		

Are you currently taking any medications? Y/N (This would include regularly used over the counter medications) **If YES please list these medications on the reverse side of this page.**

Do you have any medication allergies? Y / N If yes, please complete below			
Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date: _____

For office use only ***Date_____***

Height: _____ Weight:_____ Blood Pressure:_____/_____ Heart Rate_____

Revised 032615

Medications that you are currently taking. (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Medications not listed above that you have taken recently. (Ex: If you had an infection a month ago and took an antibiotic for it)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Patient Signature: _____ Date:_____