Massage Case History/Patient Information

Name_____ Date_____
Address_____City_____State_____Zip_____
Home phone #_____ Cell#_____ E-mail Address_____
Age_____ Birth date_____ Male___ Female ___ Marital: M S W D # of Children____

Occupation_____Employer_____
Employer's address _____Office phone #_____
Spouse _____ Employer_____
Name of nearest relative_____ Phone#_____
How were you referred to our office? _____
Family medical doctor_____Phone#_____

Purpose of this Massage _____
Symptoms appeared or accident happened_____
Massage Background: First massage_____ Date of Last Massage_____
What medications & nutritional supplements are you taking? _____
_____

Has it become worse recently? □Yes □No □Same □Better □Gradually worse
If yes, when and how?_____

How frequent is the condition? □All day □Few hours □Minutes

Describe the pain: □Sharp □Dull □Numbness □Tingling □Aching □Burning □Stabbing
□Other:_____
What makes the problem worse? □Standing □Sitting □Lying □Bending □Lifting □Twisting

Other: _____

Check the conditions that apply to you, past and present. Add your comments to clarify the condition.

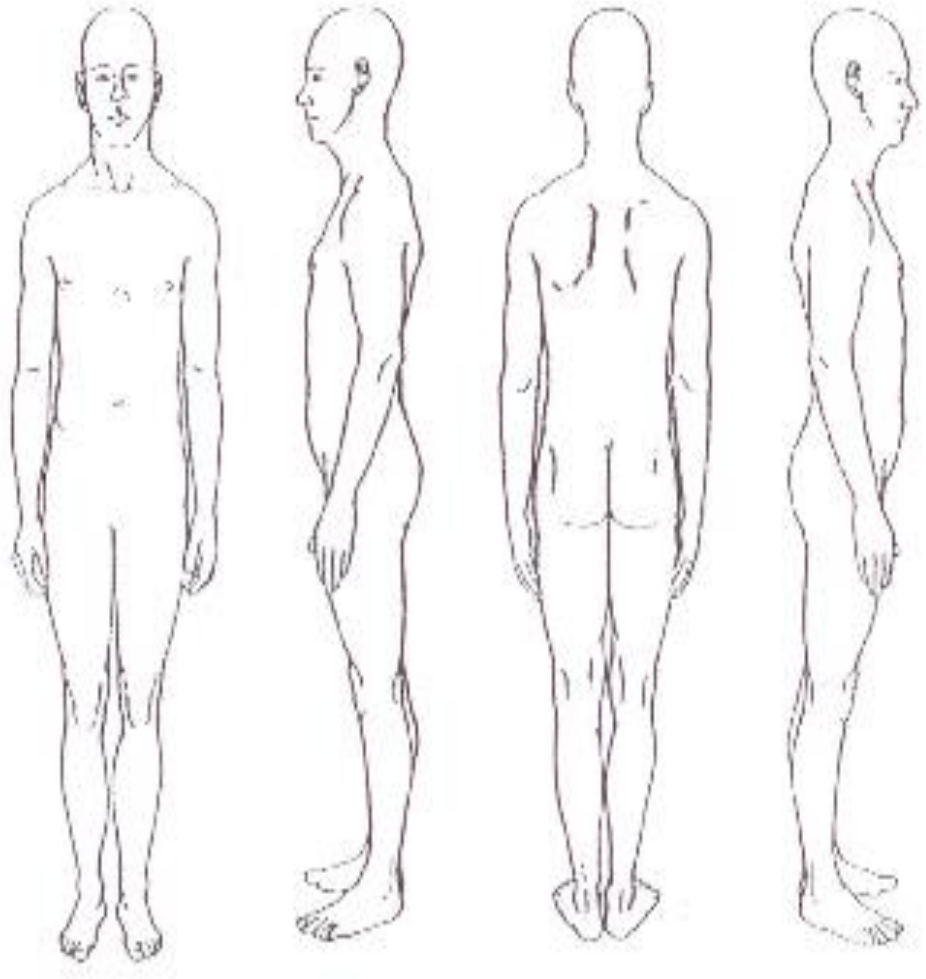
□ **Headaches**	□ **Numbness/Tingling**	□ **Fibromyalgia**
□ **Chronic Pain**	□ **Varicose Veins**	□ **Sinus Problems**
□ **Diabetes**	□ **Whiplash**	□ **Pregnant**
□ **Frequent Stress**	□ **Spasms/Cramps**	□ **Fatigue**
□ **Joint Stiffness/Swelling**	□ **Shoulder/Neck/Arm/Hand Pain**	□ **Jaw Pain/TMJ Disorder**
□ **Back/Hip Pain**	□ **Tendonitis/Bursitis**	

I understand that the bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Thus, the bodywork I receive shall not be considered a substitute for medical examination, diagnosis, or treatment by a qualified chiropractor, medical doctor or other specialist. I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness and nothing said in the course of the session will be construed as such. Because certain physical conditions may contraindicate massage, I certify that the health information I have provided is accurate: and I agree to update the clinic of any changes in this condition. I understand that my failure to do so is not the liability of the clinic or the practitioner.

***Signature:* _____*Date:* _____**

Please identify current problem area in your body by making appropriate marks on the figures below.

xxxx: areas where pain exists
-----: draw in any scars, bruises, or wounds
oooo: areas of stiffness
::::::: areas of numbness of tingling



Additional comments:_____
_____
_____

Our promise to you:

It is our greatest goal to be respectful and courteous to our patients with special attention to patient comfort levels. We will provide a comfortable, safe, clean environment using quality equipment and supplies. We will maintain high standards of personal hygiene and wear appropriate attire for the setting. We will keep patients modestly draped at all times and will remain open to comments and suggestions.

Our expectations from clients:

Please come to the massage appointment on time or reschedule with 24 hours notice. Please arrive healthy and clean. Fee for the service is required at the time of service. There is zero tolerance for sexual harassment. If this type of behavior presents itself, you will be asked to leave immediately and to pay for the session in full. If you arrive late, that time will be taken off your session and full payment is required. The patient is responsible to keep the massage therapist informed of any current medical conditions.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the massage therapist, chiropractor or chiropractic office. I authorize the massage therapist or doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of massage therapy as determined by my treating massage therapist or doctor. Fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date_____

Guardian's signature authorizing care _____ Date_____