Practitioner/Clinic Name:

Health Information

Contact Information

Client Contact Information

Client Name: Date:

Date of Birth: Gender:

Address:

Phone: Email:

Referred by:

Emergency contact: Phone:

Physician/Health-care Provider name: Phone:

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently?

What types of massage/bodywork do you prefer?

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

How do you feel today?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

List the medications you currently take:

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Practitioner/Clinic Name:

Health Information

Contact Information

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current	Past	Muscle or joint pain
Current	Past	Muscle or joint stiffness
Current	Past	Numbness or tingling
Current	Past	Swelling
Current	Past	Bruise easily
Current	Past	Sensitive to touch/pressure
Current	Past	High/Low blood pressure
Current	Past	Stroke, heart attack
Current	Past	Varicose veins
Current	Past	Shortness of breath, asthma
Current	Past	Cancer
Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain)
Current	Past	Epilepsy, seizures
Current	Past	Headaches, Migraines
Current	Past	Dizziness, ringing in the ears
Current	Past	Digestive conditions (e.g. Crohn's, IBS)
Current	Past	Gas, bloating, constipation
Current	Past	Kidney disease, infection
Current	Past	Arthritis (rheumatoid, osteoarthritis)
Current	Past	Osteoporosis, degenerative spine/disk
Current	Past	Scoliosis
Current	Past	Broken bones
Current	Past	Allergies __
Current	Past	Diabetes
Current	Past	Endocrine/thyroid conditions
Current	Past	Depression, anxiety
Current	Past	Memory Loss, confusion, easily overwhelmed

Comments:

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: Date:

Parent or Guardian Signature (in case of a minor): Date:

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Law requires the privacy of your health information be maintained and that you are provided this notice of the legal duties and privacy practices with respect to your health information. Other than the uses and disclosures we described below, your health information will not be sold or provided to any outside marketing organization.

We must abide by the terms of this notice and we reserve the right to change the terms of this privacy notice. If a change is made, it will apply for all of your health information in our files, and you will be notified in writing.

HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

USES AND DISCLOSURES
Here are examples of use and disclosure of your health care information:

1. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your session records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run this practice.
4. We may need to use your name, address, phone number, and your records to contact you to provide appointment reminder calls, recall postcards, Welcome and Thank You cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES
You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION
Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

1. We are providing services to you based on the orders (referral) of a health care provider.
2. We provide services to you in an emergency and are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION
You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION
We will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

AMENDING YOUR HEALTH INFORMATION
You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

INSPECTING/COPYING YOUR HEALTH INFORMATION
You have the right to inspect the your files while in our office and/or have a copy made for you. The information is available up to seven years from the date that the record was created. Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of $.20 per page copied.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS
You have the right to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

Required for your session, to obtain payment for services, to run our practice, and/or made to you.
Necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
For national security, intelligence purposes, or law enforcement officers.
That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request

RE-DISCLOSURE
We cannot control the actions of others to whom we have released your information for further treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS
You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

This notice effective as of April 14, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

I, _____, give my permission for you to leave any information for me and use your name/clinic name at the following:

Home phone _____

Work phone _____

Cell phone _____

Fax _____

Client Name Printed Date

Client Signature Authorized Staff Person

Personal Representative Printed Personal Representative Signature

Description of personal representative's authority to act for the client.