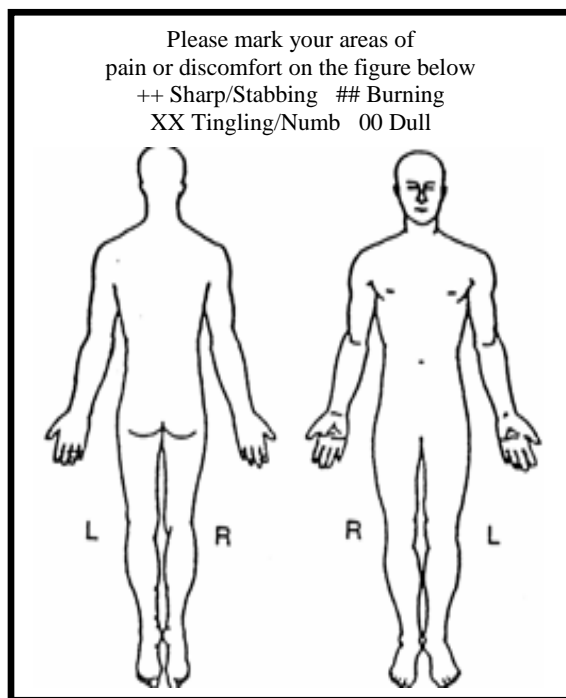


**CONFIDENTIAL PATIENT INFORMATION**

**MASSAGE**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex M F  
 Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status M S W D How many children? \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Office Ph. \_\_\_\_\_  
 Work Address \_\_\_\_\_ Email Address \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_  
 Have you previously had professional massage?  Yes  No If so, when and how often \_\_\_\_\_  
 Would you like to receive  Email Reminders  Text Reminders, Cellular Carrier: \_\_\_\_\_  
 Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.):  
 1. \_\_\_\_\_ Date: \_\_\_\_\_  
 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_

**AREAS OF COMPLAINT**



**Medication:** Please list all medications you are currently taking. We offer information on what nutrient deficiencies will be caused by the medications you are taking. If you desire this information, please inform your therapist.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

**Nutrients:** Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation, please bring your nutrients on your next visit.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

**General Medical Information:**

1. Y N Do you suffer from back pain? If so, upper, mid, lower back? \_\_\_\_\_

2. Y N Do you suffer from headaches? If so, how often? \_\_\_\_\_

3. Y N Do you have any allergies (medications, ointments, oils, etc)? If yes, please explain.  
\_\_\_\_\_

4. Are you wearing: \_\_\_\_\_ contact lenses? \_\_\_\_\_ hearing aid? \_\_\_\_\_ hair piece?

5. Check the conditions that have affected your health in the past 2 years.

- |                                |                           |                                |
|--------------------------------|---------------------------|--------------------------------|
| _____ arthritis                | _____ depression/anxiety  | _____ jaw pain or TMJ disorder |
| _____ asthma/allergies         | _____ diabetes            | _____ joint pain               |
| _____ athletes foot            | _____ digestive problems  | _____ muscle sprain/strain     |
| _____ blood clots              | _____ diverticulitis      | _____ scoliosis                |
| _____ broken/dislocated bones  | _____ fatigue             | _____ seizures/epilepsy        |
| _____ bruise easily            | _____ fevers              | _____ skin conditions          |
| _____ cancer                   | _____ fibromyalgia        | _____ sleep difficulties       |
| _____ chronic pain             | _____ heart disease       | _____ stroke                   |
| _____ chronic fatigue syndrome | _____ hepatitis           | _____ sinus problems           |
| _____ circulatory problems     | _____ high blood pressure | _____ varicose veins           |
| _____ constipation/diarrhea    | _____ infectious diseases | _____ whiplash                 |

6. Y N Do you have any other medical conditions or injuries? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diet/Lifestyle:**

1. How much water do you drink a day? \_\_\_8-oz. glasses. What kind? Tap Filtered Distilled

2. How many times do you eat fast food each week? \_\_\_\_\_

3. What are your health goals for the upcoming 6 months? \_\_\_\_\_

4. Do you have any food allergies? If yes, please name: \_\_\_\_\_

5. On a scale of 1 to 10, what level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10

6. On a scale of 1 to 10, what is your commitment to making a lifestyle improvement? 1 2 3 4 5 6 7 8 9 10

**Female Only:**

Is there any chance you are pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how many weeks? \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT CONSENT FORM

### FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, \_\_\_\_\_, hereby state that by signing this consent, I acknowledge and agree as follows:

\_\_\_ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

\_\_\_ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

\_\_\_ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

\_\_\_ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

\_\_\_ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

\_\_\_ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## TERMS OF ACCEPTANCE

Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band. In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible. Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

\_\_\_ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

\_\_\_ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort.

\_\_\_ I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

\_\_\_ I affirm that I have notified my therapist of all known medical conditions and injuries.

\_\_\_ I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

I have read and understand the information above.

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_