Massage Therapy
Personal Record and Consent Form

Name:_____Referred by:_____

DOB:_____SS#:_____ Marital Status: Single Married Divorced Other

Address:_____City/State/Zip:_____

Home#_____Work#_____Cell#_____

Email Address_____

Insurance Company:_____ID#_____

Is this a car or work related accident? Yes No Date of Injury:_____

- Have you had prior massage therapy? Y N Date of last Massage:_____

TREATMENT INFORMATION

Are you currently seeing a medical practitioner? If yes please explain._____

_____

List current medications, including aspirin, ibuprofen, etc._____

_____

List any major accidents or surgeries:_____

_____

What results do you want from your massage session?_____

_____

HEALTH HISTORY

Musculo-Skeletal
_____bone disease
_____tendonitis
_____bursitis
_____arthritis
_____low back/hip/leg pain
_____neck/shoulder/arm pain
_____headaches
_____jaw pain
_____lupus
_____spasms/cramps
_____sprains/strains
_____other

Circulatory
_____heart condition
_____varicose veins
_____blood clots
_____high blood pressure
_____low blood pressure

Skin
_____allergies
_____rashes
_____athletes foot
_____warts
_____other

Digestive
_____constipation
_____gas/bloating
_____diverticulitis
_____irritable bowel
_____other

Reproductive
_____pregnant
_____PMS
_____other

Other
_____cancer/tumors
_____diabetes
_____eating disorder
_____depression
_____drug/alcohol addiction

Nervous
_____herpes
_____shingles
_____numbness
_____chronic pain
_____fatigue
_____sleep disorders

Please explain any conditions marked:_____
_____

INFORMED CONSENT

It is my choice to receive massage therapy. I realize treatment is being given for the well being of my mind and body. This includes stress reduction, relief from muscular tension/spasms/pain, and the increase of circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I understand that I am responsible for all payments under any circumstances. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

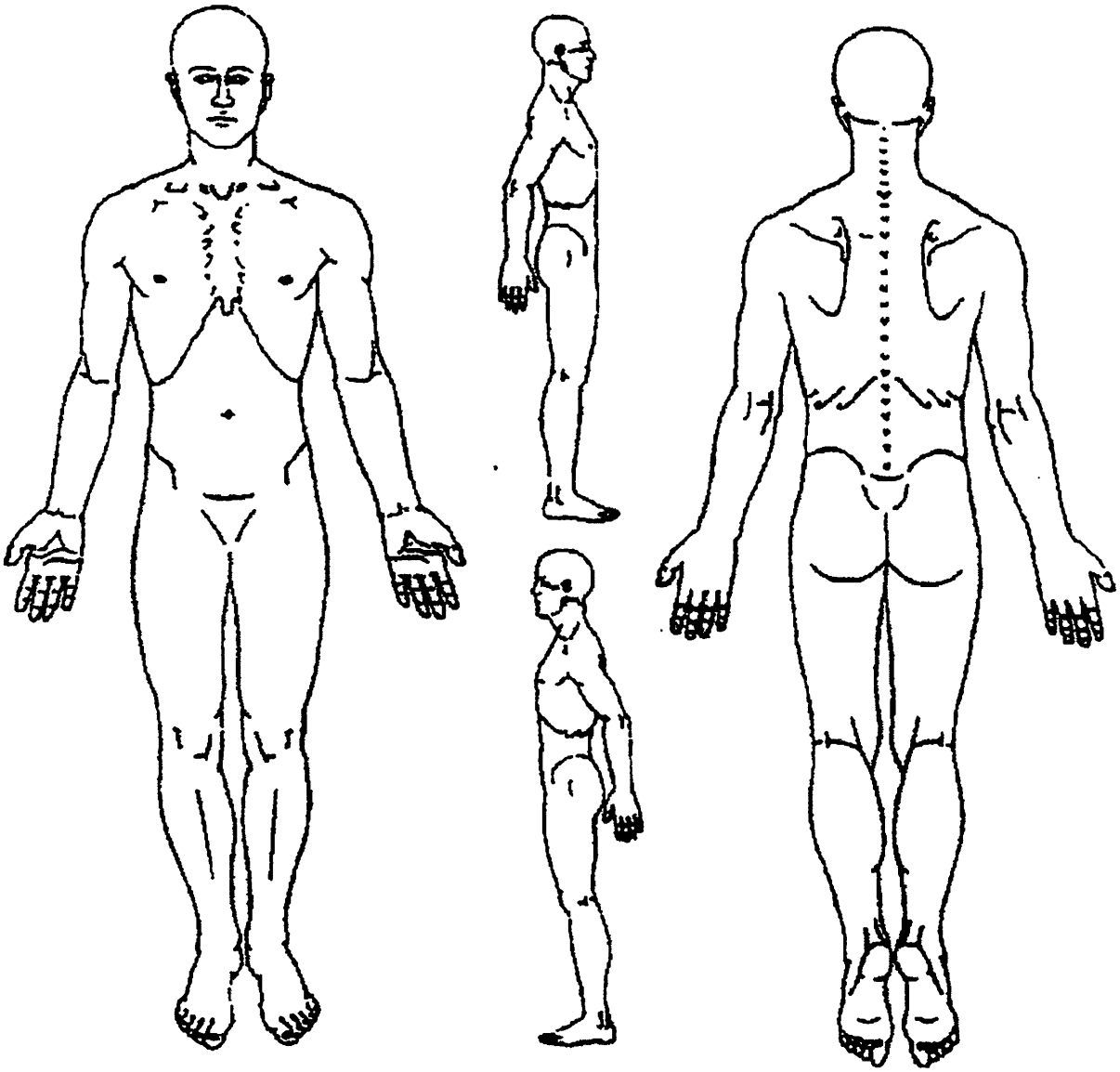
SIGNATURE:_____DATE:_____

Massage Subjective Assessment

Please use the following symbols to accurately mark the areas in which you feel any of the described sensations. Include all affected areas.

Dull pain: N N N Stabbing/ Cutting: /// /// /// Burning: X X X

Numbness: = = = Tinging (Pins & Needles): ::: ::: ::: Cramping: S S S



Please place one mark on each line below to indicate your response:

1. What is your pain RIGHT NOW?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

2. What is your TYPICAL or AVERAGE pain?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

3. What is your pain at its WORST?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

Applied Healthcare Associates, P.S.
Consent for Purposes of Treatment, Payment and Healthcare Operations

I,_____(Name of Individual) consent to Applied Healthcare Associates, P.S.("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to quality assessment, activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition, the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand that I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ _____

Signature of Patient or Guardian Print Patient Name or Guardian

_____

Date

- ***Initals:_____*** ***Missed Appointments:*** **Changes in appointments require a 24-hour advance notice.** ***There will be a $25 fee charged for all missed chiropractic appointments, and $35 for all missed massage appointments.*** **It is also very important to follow your treatment plan to get and stay well!**

- **Initials:_____ Payment:** It is our office policy that payment is made at the time of service. If you participate in an *Optimal Health Plan*, *Wellness Plan*, or *Insurance Health Plan*, payment is due as stated in your plan guidelines. Any returned payment for NSF is charged a $25.00 fee.

- **New Injury or Auto Accident:** If you experience a new injury, re-injury or exacerbation on an existing condition, please notify us as soon as possible so that the doctor can give immediate attention. If you have been involved in an auto accident please let our office staff know upon making your appointment so we can be sure to make time for appropriate care and examination.