Massage Therapy

CONFIDENTIAL HEALTH HISTORY

This information is needed so we can better serve you. Please fill in ALL portions of the form.
If you need assistance, we would love to help! Please print clearly.

Name: First: _____ Middle: _____ Last: _____

Address _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Occupation: _____ Email: _____ Birth Date: ___/___/___

How did you hear about us?

Who to contact in case of emergency? Phone:

Primary Care Physician: Phone:

Medical Information: Do you have, or have had, a history of any of the following?

☐ Headaches	☐ Allergies	☐ High Blood Pressure	☐ Recent injurie(s)
☐ Epilepsy	☐ Arthritis	☐ Circulatory Problems	☐ Recent Illness
☐ Insomnia	☐ Digestive Problems	☐ Sinusitis	☐ Pregnant – currently ____ weeks
☐ Cardiac Problems	☐ Asthma	☐ Constipation	☐ High Risk Pregnancy
☐ Varicose Veins	☐ Cold hands/feet	☐ Diabetes	☐ Cancer
☐ Joint pain	☐ Neck restriction	☐ Recent Surgeries	
☐ Other Medical Conditions:			

Do you take medications? ☐ yes ☐ no	List Over The Counter & Prescriptions:	Purpose of meds?

Have you had professional body work/massage before?
☐ yes ☐ no If yes, when and what kind? _____

X: _____ ___/___/___

Signature: **Date:**

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Please explain why are you here?

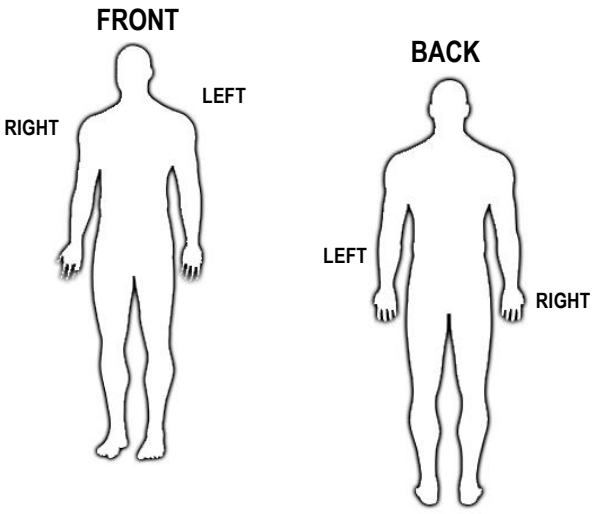
When did this issue/injury begin? / /
Have you ever had similar concerns in the past? ❑No ❑ Yes, If Yes, When? / /

Use diagrams to indicate pain or numbness.

Draw an **X** for location of **pain**

Circle ○ areas of **numbness** and/or **tingling**

Use → to show if **pain travels** from one area to another



Rate your current level of pain with an X:

(0 = No Pain and 10 = Unbearable pain)

|---|---|---|---|---|---|---|---|---|---|

0 5 10

✓ **all that apply:**

My pain is: ❑Constant ❑Intermittent ❑Sharp ❑Dull ❑Stabbing ❑Burning ❑Other_____

I experience: ❑Numbness ❑Burning ❑Cramping ❑Tingling ❑Other_____

Is there anything else you would like me to know:

X: / /

Signature: **Date:**

Massage Therapy

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Consent to Use and Disclose of Health Information

This notice describes how massage and medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

In the course of your care as a massage client at Austin Chiropractic Center, we may use or disclose personal health related information about you only when necessary. Your protected health information, including your clinical records, may be used by our staff or disclosed to another party such as:

-another healthcare provider if it is necessary to refer you for further diagnosis, assessment or treatment.
- an insurance carrier, an HMO, PPO or employer if they are responsible for the payment of services provided to you.
-your name, address, phone number may be used to contact you regarding appointment reminders or other health information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:
-If we provide healthcare services to you in an emergency.
-If we are required to provide care to you and we are unable to obtain your consent after attempting to do so.
-If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
-If we are ordered by the courts or another appropriate agency.
You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information, you have the right to revoke that authorization at any time. You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

X: _____ / / _____

Signature: **Date:**

Consent to Treat

I understand and am informed that, as in all health care, in the practice of Massage Therapy there are some rare risks to treatment, including but not limited to, muscle strain.

X: _____ / / _____

Signature: **Date:**