Name____Phone: Home________________Work______________

Address____City_________________________Zip_________

D.O.B.________________________ Male_______ or Female________Occupation________________________

Primary Physician:____Telephone:________________________

Do You Grant Permission to Consult with Primary Provider? No_____or Yes______ (please initial if yes)__________

In Case of Emergency, Please Notify:

Name:____________________________________Telephone:____________ or____________________

Relationship:____

Client Health Information Sheet

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Who referred you to this office? Name:____

Present symptoms:

What is your major complaint or condition you want to improve? __________________________________

What activities aggravate the condition?___________Is this condition getting progressively worse?___Y ___N

Does this condition interfere with Work? ____Y ____N, Sleep? ____Y ____N, Daily routine?____Y ___N

What have you done to get relief?____

Has there been a medical diagnosis?_____Y _____N Physician:____________________ Diagnosis:____________

Have you had X-rays taken?____Y ____N

Are you currently under medical/therapeutic treatment? _____Y _____N

If yes, for what condition?____

Please list any medications you are taking:____

Describe the exercise activities you do (include frequency)____

List other complimentary therapies you utilize: (chiropractic, acupuncture, etc.)_______________________________

When was your last therapeutic massage?____

Health History

___**Yes** ___**No** Do you frequently suffer from stress?

___**Yes** ___**No** Do you experience frequent headaches?

___**Yes** ___**No** Are you pregnant?

___**Yes** ___**No** Are you wearing contact lenses?

___**Yes** ___**No** Are you wearing dentures?

___**Yes** ___**No** Do you suffer from arthritis?

___**Yes** ___**No** Do you have osteoporosis?

___**Yes** ___**No** Do you have cardiac or circulatory problems

___**Yes** ___**No** Do you have diabetes?

___**Yes** ___**No** Do you have varicose veins?

___**Yes** ___**No** Do you have any contagious diseases?

___**Yes** ___**No** Do you have any allergies?

___**Yes** ___**No** Have you had any broken bones in the past 2 years?

___**Yes** ___**No** Do you bruise easily?

___**Yes** ___**No** Do you suffer from back pain?

___**Yes** ___**No** Do you have high blood pressure? Medications____

___**Yes** ___**No** Do you suffer from seizures?____

___**Yes** ___**No** Do you have tension or soreness in a specific area?_____________________________________

___**Yes** ___**No** Do you have numbness or stabbing pains anywhere?____________________________________

___**Yes** ___**No** Are you very sensitive to touch or pressure anywhere?__________________________________

___**Yes** ___**No** Have you had any accidents or operations within the last 3 years:___________________________

Other Comments:____

I,____________________________(client), understand that massage therapy provided by Myotherapy Family Massage Center is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that spinal manipulations are not part of massage therapy.
I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

____ ____________________

Client Signature Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES:

1. Intake form is a medical history that informs the massage therapist about a potential contraindication of massage.
2. Appointment book is kept out of sight for the exclusive use of our receptionist and massage therapists.
3. S.O.A.P. notes are recorded after each session to document therapies used.
   These records are kept in a locked filing cabinet and may be shared during litigation or for insurance purposes when a formal subpoena and your written consent have been filed with us.
4. We may contact you, using the contact information you have provided to us, for the purpose of scheduling appointments.

AUTHORIZATION:

Any uses and disclosures other than those above will only be made with your authorization. You maintain the right to revoke such authorization.

STATEMENT OF INDIVIDUAL RIGHTS:

1. You have the right to request restrictions on the uses and disclosures of your protected health information. We may reserve the right to refuse the request.
2. You have the right to receive confidential communications.
3. You have the right to inspect and copy your protected health information.
4. Your have the right to amend your protected health information.
5. You have the right to receive a paper copy of this notice upon request.
6. You have the right to obtain access to this information by written request to our privacy officer.

Myotherapy Family Massage Center has a legal requirement to maintain privacy of protected health information, provide a notice of our duties and to abide by the terms of this notice. Myotherapy Family Massage Center reserves the right to change and revise its privacy practices regarding previously created or received protected history information. We will provide you with notice of any revision and changes in our policy.

COMPLAINT PROCEDURES:

If you feel that your privacy rights have been violated you may file a complaint with Myotherapy Family Massage Center by contacting Ali McConville 1827 Main St., Lafayette, In 47904 or at 765-423-2536.

Effective April 14, 2003

I, the undersigned, have read and understand the privacy policy of Myotherapy Family Massage Center and consent to the use and disclosures of my protected health information as described herein.

______________________________ ______________

Client Signature Date