ABSOLUTE Wellness

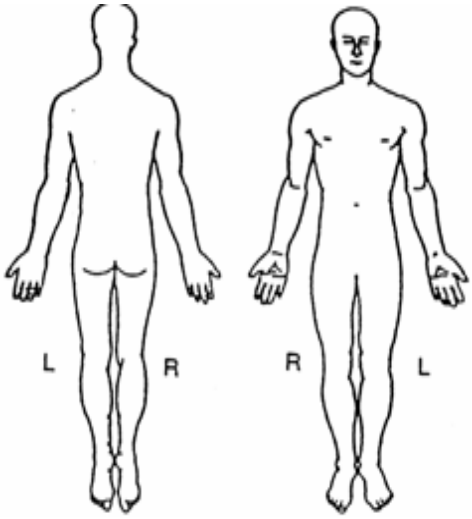
CONFIDENTIAL PATIENT INFORMATION MASSAGE ONLY

Name _____ SSN _____ Date _____
Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Sex □ M □ F Birthdate _____ Age _____
Occupation _____ Employer _____
Work Address _____ Work Phone _____
Who may we thank for referring you?_____ Marital Status S M W D
Spouse's Name _____ Spouse's Employer _____
Have you had chiropractic care previously? □ No □ Yes When _____ Doctor's Name _____
Would you like to receive reminders? □ Text □ Email Cellular Carrier _____
Please list your most recent traumas with date of occurrence. (Auto Accidents, Falls, Sports Injuries, Etc.) _____
_____
_____

Areas of Complaint

Please mark your areas of pain on the figure. Use the corresponding character to indicate the type of pain in each area.

++ Sharp/Stabbing
Burning
XX Tingling/Numb
00 Dull



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

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 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. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Females Only

Is there any chance you are pregnant? □ No □ Yes

General Medical Information

1. Do you suffer from back pain? □ No □ Yes….□ Upper □ Mid □ Lower
2. Do you suffer from headaches? □ No □ Yes….How often? _____
3. Do you have any allergies? (medications, ointments, oils, etc.) □ No □ Yes…Please explain._____
_____
4. Are you wearing any of the following? □ Contact Lenses □ Hearing Aids □ Hair Piece
5. Check the conditions that have affected your health in the past 2 years.

□ arthritis	□ asthma/allergies	□ athlete's foot	□ blood clots	□ broken/dislocated bones
□ bruise easily	□ cancer	□ chronic pain	□ chronic fatigue syndrome	□ circulation problems
□ constipation	□ diarrhea	□ depression/anxiety	□ diabetes	□ digestive problems
□ diverticulitis	□ fatigue	□ fevers	□ fibromyalgia	□ heart disease
□ hepatitis	□ high blood pressure	□ infectious disease	□ jaw pain or TMJ	□ joint pain
□ muscle sprains/strains	□ scoliosis	□ seizures/epilepsy	□ skin conditions	□ sleep difficulties
□ stroke	□ sinus problems	□ varicose veins	□ whiplash	□ _____
□ _____	□ _____	□ _____	□ _____	□ _____

Diet/Lifestyle

From 1-10, what is your daily stress level? _____
From 1-10, how committed are you to making lifestyle improvements? _____

Substance	Used?	Type	How Much/How Often
Water	□ Yes □ No		_____Glasses Per Day
Caffeinated Beverages	□ Yes □ No		_____Per Day
Alcohol	□ Yes □ No		_____Per Week
Fast Food	□ Yes □ No		_____Per Week

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 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.

Patient's Name Printed _____ Signature _____ 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.

____ 1. I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

____ 2. 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.

____ 3. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

____ 4. I affirm that I have notified my therapist of all known medical conditions and injuries.

____ 5. 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.

Patient's Name Printed _____ Signature _____ Date _____

I verify that the information I have provided in this document is true and I give the therapist consent to treat me.

Patient's Name Printed _____ Signature _____ Date _____

MASSAGE CANCELLATION POLICY

Massage therapy at Absolute Wellness is used for both relaxation and treatment in conjunction with chiropractic care. Due to the limited number of available appointment, we must enforce a cancellation policy.

Patients must provide no less than **24-hours notice** for cancelling a massage therapy appointment. If sufficient notice is not received, a **$30 cancellation fee** will be charged at the patient's next office visit. This charge is the responsibility of the patient. Insurance will not be billed to cover this fee.

I, _____, understand that it is my responsibility to cancel massage appointments **24-hours** prior to my scheduled appointment. I understand that I will be charged and agree to pay a **$30 cancellation fee** should I fail to do so.

Signature _____ Date _____