Massage Intake - Bellevue Therapeutic Massage

4122 Factoria Blvd SE Suite 203, Bellevue, WA 98006 – 425.590.9620

Name _____ Date _____

Phone (C) (H) (W) _____ (C) (H) (W) _____

Address _____ City _____

State _____ Zip _____ Date of Birth _____

E-mail _____

Marital Status: Single Married Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Were you referred by anyone? Y N If so, who? _____

Have you ever received massage therapy? Y N If so, what type? □ Treatment □ Spa □ Other

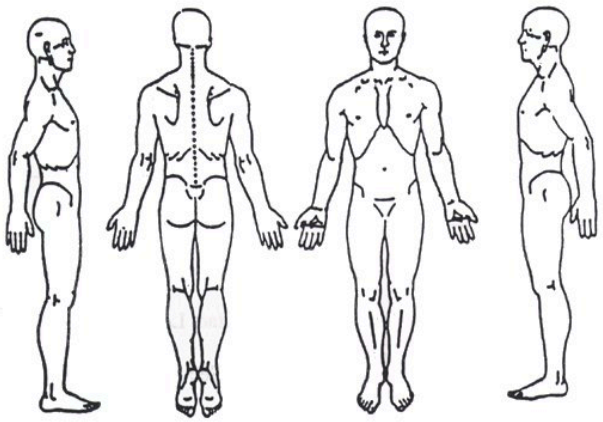
Are you seeking treatment because of an auto or work-related injury? ? Y N

If yes, when was the injury? _____ What kind of injury? _____

Are there any other health conditions I should be aware of? Y N If yes, please explain _____

_____

- Shade in any area below where you feel discomfort -



How much are you active each week?

□ Less than one hour □ Three to four hours

□ One to two hours □ Five or more hours

Which activities? _____

_____

_____

How much water do you drink per day?

□ Less than two glasses □ Five or more glasses

□ Two to four glasses

Please read and initial the following:

_____ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

_____ I am responsible for paying a fee for any appointment cancellation of less than 24 hours, or for no-shows.

_____ I will notify the office as soon as I can to reschedule or discuss the issue if I have a fever, sunburn, flu, or anything contagious.

_____ I understand that massage therapy may or may not be covered under my insurance policy, and payment is ultimately my responsibility.

Signature _____ Date _____

Health History

Check the following conditions that apply to you, past and current. Please circle area of concern if there are multiple choices, and add your comments where necessary.

Past Now ***Musculo-Skeletal***

- ☐ ☐ Headaches/Migraines
- ☐ ☐ Joint stiffness/swelling
- ☐ ☐ Spasms/cramps
- ☐ ☐ Broken/fractured bones
- ☐ ☐ Strains/sprains
- ☐ ☐ Back, hip pain
- ☐ ☐ Shoulder, neck, arm, hand pain
- ☐ ☐ Leg, foot pain
- ☐ ☐ Chest, ribs, abdominal pain
- ☐ ☐ Problems walking
- ☐ ☐ Jaw pain/TMJD
- ☐ ☐ Tendinitis
- ☐ ☐ Bursitis
- ☐ ☐ Arthritis
- ☐ ☐ Osteoporosis/Osteopenia
- ☐ ☐ Scoliosis
- ☐ ☐ Bone or joint disease
- ☐ ☐ Other: _____

Past Now ***Nervous System***

- ☐ ☐ Numbness/tingling
- ☐ ☐ Twitching of face
- ☐ ☐ Fatigue
- ☐ ☐ Chronic pain
- ☐ ☐ Sleep disorders
- ☐ ☐ Ulcers
- ☐ ☐ Paralysis
- ☐ ☐ Herpes/shingles
- ☐ ☐ Cerebral Palsy
- ☐ ☐ Epilepsy/Seizure Disorder
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Muscular Dystrophy
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Spinal cord injury
- ☐ ☐ Other: _____

Past Now ***Circulatory and Respiratory***

- ☐ ☐ Dizziness
- ☐ ☐ Shortness of breath
- ☐ ☐ Fainting
- ☐ ☐ Cold feet or hands
- ☐ ☐ Pressure sores
- ☐ ☐ Varicose veins
- ☐ ☐ Blood clots
- ☐ ☐ Stroke
- ☐ ☐ Heart condition
- ☐ ☐ Allergies: _____
- ☐ ☐ Sinus problems
- ☐ ☐ Asthma
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Lymphedema
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Deep Vein Thrombosis
- ☐ ☐ Pacemaker
- ☐ ☐ Hemophilia
- ☐ ☐ Other: _____

Past Now ***Skin***

- ☐ ☐ Rashes
- ☐ ☐ Allergies
- ☐ ☐ Athlete's Foot
- ☐ ☐ Warts, where? _____
- ☐ ☐ Cosmetic Surgery
- ☐ ☐ Other: _____

Past Now ***Digestive***

- ☐ ☐ Indigestion
- ☐ ☐ Constipation
- ☐ ☐ Diverticulitis/Diverticulosis
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Crohn's Disease
- ☐ ☐ Colitis
- ☐ ☐ Other: _____

Past Now ***Reproductive System***

- ☐ ☐ Pregnancy:
  If current, due date: _____
- ☐ ☐ PMS
- ☐ ☐ Pelvic Inflammatory Disease
- ☐ ☐ Endometriosis
- ☐ ☐ Hysterectomy
- ☐ ☐ IUD
- ☐ ☐ Hormone Replacement Therapy
- ☐ ☐ Other: _____

Past Now ***Other***

- ☐ ☐ Confusion
- ☐ ☐ Depression
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Drug use: _____
- ☐ ☐ Alcohol use: _____
- ☐ ☐ Nicotine use: _____
- ☐ ☐ Caffeine use: _____
- ☐ ☐ Hearing impaired
- ☐ ☐ Diabetes
- ☐ ☐ Fibromyalgia
- ☐ ☐ Post/Polio Syndrome
- ☐ ☐ Cancer: _____
- ☐ ☐ Infectious disease: _____
- ☐ ☐ Surgeries: _____
  When: _____
- ☐ ☐ Other congenital, autoimmune or acquired disabilities: _____
  _____
- ☐ ☐ Other: _____

Please list any additional comments regarding your health and well-being: _____

_____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Signature: _____ Date: _____

Cancellation Policy

Here at Bellevue Therapeutic Massage, we strive to accommodate the appointment needs of our clientele to the best of our abilities. In order to maintain a high functioning office and serve the needs of all our patients, we ask you to agree to the following policies:

1. Late Policy: As we often have clients booked in succession, massage appointments end at the scheduled time, no matter the patient arrival time or duration of massage.

2. Cancellation Policy:

   If a patient chooses to cancel or reschedule an appointment with more than 24 hours notice, no fee is applied. We try to be flexible and accommodating as best we can.

   Same day cancellation: If a massaged is canceled on the same day or within 24 hours of the appointment, a $30 fee applies.

3. No Shows Policy: If a patient is schedule and does not arrive for his or her scheduled appointment, then a $30 cancellation fee will be charged.

By signing below, I am agreeing to the policies listed above.

Name_____ Date_____

Signature _____

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations - HIPAA

I, _____, understand that as part of my health care, PrimeSpine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Health Information and Privacy Practices that provides a more complete description of information uses and disclosure, and I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that PrimeSpine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PrimeSpine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Chiropractic USA change their notice, they will send a copy of any revised notice to the address I've provided (whether U S mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient's Signature _____ Date _____