



CLIENT INFORMATION SHEET

Name: _____ Date: _____
Last First M.I.

Street Address: _____

Apt# _____ City: _____ Zip: _____

Phone - home: _____ Cell: _____ Wk: _____

Email: _____ D.O.B: _____
(permission to send promotions and updates)

Occupation: _____ Employer: _____

Reason for Appointment: _____

_____ Work Related: Yes ___ No ___

Emergency Contact or Relative:

Name: _____ Phone: _____

Are you currently being treated by a Doctor or Chiropractor? Yes ___ No ___

If Yes, provide contact information for your Doctor:

Name: _____ Address: _____

Phone: _____ Email: _____

Do you have any injuries, bruises, or illness we need to know about?
(fever, sprains, inflammation, rashes, skin conditions, skin allergies, etc.)

No ___ Yes/explain: _____

How much water do you drink a day? _____ Do you Exercise/Stretch? Yes ___ No ___

How many raw fruits and vegetables are in your daily diet? _____

HEALTH STATUS

Patient Name _____ Subscriber ID # _____ Date _____

Primary Language _____ What is your occupation? _____

Describe Your Current Problem and How It Began _____

Onset date _____

Is this? Work Related Auto Related N/A

How often are your symptoms present?

Constantly (76-100% of the day) Occasionally (26-50% of the day)

Frequently (51-75% of the day) Intermittently (0-25% of the day)

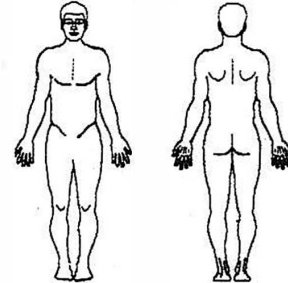
Describe the nature of your pain:

Sharp Dull Ache Numb Shooting Burning Tingling

How is your condition changing?

Getting Better Not Changing Getting Worse

Indicate below where you have pain or other symptoms



Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

Excellent Very Good Good Fair Poor

Please check all of the following that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Numbness (location) _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Cardiac Condition | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> Current Medications _____ |

Who have you seen for your condition before today?

No One Medical Doctor Massage Therapist Other _____
 Chiropractor Physical Therapist Acupuncturist

What treatment did you receive and when? _____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my provider to contact my physician, if necessary.

Patient Signature _____ Date _____



MASSAGE POLICIES

My requirements of clients:

Sessions begin and end at scheduled times. Sessions that begin late due to the client arriving late will end at the appointed time. The full price will be charged.

Be present (not under the influence of drugs or alcohol).

Sexual harassment is not tolerated. If the practitioner's safety feels compromised the session is stopped immediately.

Payment is expected at the time service is rendered.

Less than a 24 hour notice = 50% of your appointment charge. It will be due prior to your next appointment.

What clients can expect from me:

I provide my clients with a competent and professional session each time they come for an appointment, addressing the client's specified needs for that session.

I am available to my clients between the hours of 9am and 6pm, Monday thru Friday.

I perform services for which I am qualified. I refer the client to the appropriate specialists when work is not within my scope of practice.

My equipment and supplies are clean and safe.

Personal and professional boundaries are respected at all times.

I provide a caring environment with a healing atmosphere that is relaxed and stress free and will focus on whole body wellness.

Print Name

Signature

Date



NOTICE OF PRIVACY PRACTICES

In accordance with The Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding this center's use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by Body of Health.

Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us and we will disclose health information about you to that doctor. For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your medical massage therapist needs to know about, while your medical massage therapist will share all findings with the prescribing doctor.

We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about treatment you are going to receive to determine whether your plan will cover it. Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for medical massage.

Although your health record is the physical property of Body of Health, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions and medical and billing records.

If you believe that health information we have about you is incorrect or incomplete, you may request in writing that we amend your health information for as long as this office keeps the information.

Our disclosure of your health information is limited to: this office, the physician who prescribed physical medicine, your insurance company, your attorney, and you. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient, and the patient's health information will be disclosed to the parents or guardian.

If you believe your privacy rights have been violated, you may file a written complain to the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Room 509 F, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.

By signing this form, you hereby acknowledge that the Body of Health may release your Protected Health Information to carry out payment and treatment operations.

I have read and understand the Notice of Privacy Practices of the Body of Health.

Signature

Date



DISCLAIMER

- As a client, it is my choice to receive therapeutic treatments at Body of Health.
- I understand that bodywork, massage therapy, and lymph drainage are for the purpose of assisting me in my healing of body/mind/spirit, stress reduction, relief from muscular tension or spasm, increasing circulation, improving energy and lymphatic flow, and increasing mobility of the tissues.
- I understand that massage therapists do not diagnose illness, disease or any other physical or mental disorder; and do not prescribe medical treatment of any kind.
- I acknowledge that massage is not a substitute for medical examination or treatment.
- I understand that Body of Health does not claim to cure illness, disease or disorder.
- Body of Health provides services to help me heal quicker, hurt less and have a better quality of life. I understand that there is no guarantee of the response my body has to the treatments given.
- I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of a session should be considered as such.
- Because massage/bodywork should not be performed under certain circumstances, I affirm that I have honestly and fully reported all of my known medical conditions to the therapist and agree to update this report should any such condition change. I understand there shall be no liability on the practitioner's part should I fail to report such information prior to treatment.

Signature

Date