FULL POTENTIAL CHIROPRACTIC
CREATING FULL POTENTIAL FAMILIES

135 E. Superior St.
Wayland, MI 49348

MASSAGE CLIENT INTAKE FORM

Name: _____ Date: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Date of Birth: _____
Occupation: _____ Employer: _____
Referred By: _____ Physician: _____
Have you ever had a massage before:

_____

What kind of massage are you looking for? Ex. Deep Tissue, Relaxing, etc.

_____

Emergency contact – Name and Number:

_____

Please mark an (X) for all conditions that apply now.
Mark a (P) for past conditions or an (F) for family history of illness.

__ headaches, migraines
__ vision problems, contact lessens
__ hearing problems, deafness
__ injuries to face or head
__ sinus problems
__ heart, circulatory
__ jaw pain, TMJ problems
__ asthma or lung conditions
__ constipation, diarrhea
__ hernia
__ birth control, IUD
__ chronic pain
__ muscle or joint pain
__ muscle, bone injuries
__ numbness or tightening
__ sprains, strain
__ arthritis, tendonitis
__ cancer, tumors
__ spinal column disorders
__ diabetes
__ high/low blood pressure
__ fatigue
__ tension, stress
__ depression
__ sleep difficulties
__ allergies, sensitivities
__ athletes foot
__ infectious diseases
__ blood clots
__ varicose veins
__ pregnancy

Explain any areas noted above:

_____

Current medications, including aspirin, ibuprofen, herbs, supplements, etc.

_____

Surgeries: _____
Accidents: _____
Please list all forms and frequency of stress reduction activities, hobbies, exercise:

_____

A $25 cash fee will be incurred for any massages missed or canceled with less than a 24 hour notice.

Signature: Date:

_____

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INFORMED CONSENT

I understand that the massage given to me by Full Potential Chiropractic, P.C. is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons state here).

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have state all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Signature: **Date:**

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Signature: **Date:**

MEDICAL INFORMATION RELEASE FORM

(__) I authorize the release of information including medical records, appointments, financial information. This information may be released to:

(__) Spouse _____ (__) Child(ren) _____

(__) Other _____ (__) Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages: If unable to reach me:

(__) You may leave a detailed message. (__) please leave a message asking me to return your call.

Signature: **Date:**
