Houk Chiropractic Clinic's Massage Therapy Intake Form

9720 N. Nevada
Spokane WA 99218
Phone: 464-2273
Fax: 242-1854

3809 N. Monroe
Spokane WA 99205
Phone 326-3795
Fax 325-7418

Personal Information

First Name: ____________ MI: ______ Last Name: ____________

Address: ____________

City: ____________ State: ______ Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Social Security #: ____________ DOB: ____________ Age: ______

Sex: M / F Marital Status: M / S / D / W Occupation: ____________ Employer: ____________

Spouse's Name: ____________ Spouse's DOB: ____________

Family Physician: ____________ Number: ____________ Fax: ____________

Emergency Contact: ____________ Relation: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Have you ever received a therapeutic massage before? ○Yes ○No If Yes, Where? ____________

Who can we thank for referring you to our office? ____________

What are your goals for massage? ____________

Would you also consider consulting with one of our Chiropractors? ○Yes ○No ○Maybe

Current Health

Are you currently taking any medications? ○Yes ○No If yes, what? ____________

Do you have a history of any surgeries? ○Yes ○No If Yes, please give the date and condition. ____________

____

Recent surgeries *(within the last 6 months to a year)* ____________

Do you have any medical conditions that the practitioner needs to be aware of? ○Yes ○No

If yes please explain. ____________

Are you pregnant? ○Yes ○No If yes, when are you due?____________

Do you have any of the following....

- ○ Arthritis
- ○ Heart Problems
- ○ Cancer
- ○ Disease or Illness
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Skin Disorder
- ○ Allergies
- ○ HIV / Hepatitis
- ○ Other, Please explain ____________

Major Complaint Information

What is the reason you are seeking massage therapy treatment?

○On going pain ○Recent Injury or accident ○Car Accident ○Preventative care

Please provide date of injury or accident: ______________________________

When did your symptoms begin? ______________________________

What aggravates your symptoms? ______________________________

Have you seen a doctor for this complaint? ○Yes ○No If yes, who? ______________________________

Describe your pain? ○Sharp○Stabbing ○Burning ○Dull Ache ○Numbness ○Tingling ○Tight/Stiff

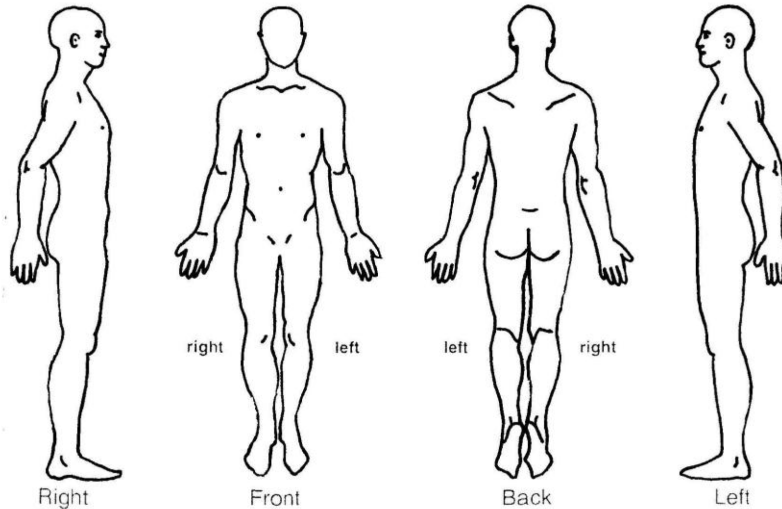
How often do you feel this way?

○Constant ○Intermittent ○With movement ○Other ______________________________

Draw your symptoms on the figure

1. Identify Current symptomatic areas on your body by marking letters on the figure below. Use the letters provided in the key to identify the symptoms you are feeling
2. Circle the area around each letter, representing the size and shape of each symptom

KEY: P= pain or tenderness S= joint or muscle stiffness N= Numbness or tingling



Identify the intensity of your symptoms

1. Pain Scale: Mark a line on the scale to show the amount of pain you are experiencing today.

   (No Pain) 1 ____________ 2 ____________ 3 ____________ 4 ____________ 5 (Unbearable Pain)

2. Activities Scale: Mark on the scale to show the limitations you are experiencing in your daily activities.

   (No Pain) 1 ____________ 2 ____________ 3 ____________ 4 ____________ 5 (Unbearable Pain)

Read and Sign

I understand that Massage Practitioners do not diagnose illness, disease, or any physical or mental disorders. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I understand by signing I give my consent to receive massage therapy on all future sessions.

Signature: ______________________________ Date: ______________________________

(Must be 18 years or older to sign)

If signing on behalf of the patient please state your relationship: ______________________________

HIPAA PRIVACY PRACTICE NOTICE

Our Office Was Designed With You In Mind!
The goal of our office design was to create a warm, open, friendly, and peaceful environment for our patients. During consultations and examinations, doors to the rooms are closed and encounters with our patients are quite confidential. Please let us know if additional privacy is needed.

Practice Requirements

The Practice:

(a) Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Personal Health History.
(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions provided under federal law.
(c) Is required to abide by the terms of this Privacy Notice
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Personal Health History that it maintains.
(e) Will distribute any revised Privacy Notice to you prior to implementation.
(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is effective as of 04/15/03

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this Notice, and I understand and agree to its terms.

Patient Signature: ________________________________ **Date:** ___________________

NOTICE OF RELEASE OF INFORMATION

I,______________________________ authorize Houk Chiropractic to discuss and/or release my health care information to the following people:

Name	**Relationship to patient**
_________________________________	____________________________________
_________________________________	____________________________________
_________________________________	____________________________________

Patient Signature: ________________________________ **Date:** ___________________

Massage Therapy Consent to Treat

Please Read and Sign:

I understand that Massage Practitioners **do not** diagnose illness, disease, or any physical or mental disorders. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I understand by signing I give my consent to receive massage therapy on all future sessions.

Patient Name: ______________________________

Patient Signature: ___________________________ Date _______________________

(Must be 18 years or older to sign)

If signing on behalf of the patient please state your relationship: ___________________