PATIENT INITIAL PAPERWORK

GENERAL

NAME:_____ AGE:_____

WORK PHONE: _____ CELL PHONE:_____

EMAIL:_____

BIRTHDATE:_____ EMPLOYER:_____

PREFERENCES

Please check any areas you experience pain or tension:

☐ Head	☐ Neck	☐ Shoulders
☐ Arms	☐ Wrists	☐ Hands
☐ Lower Back	☐ Hips/legs	☐ Mid Back

Are you taking any medications?: _____

Do you have any recent injuries?: _____

Have you had a recent illness?: _____

Have you received chair massage before?

☐ Yes ☐ No

CONSENT

Informed Consent for Massage Therapy

I give the doctors, massage therapist, and staff permission to perform massage therapy treatment. I acknowledge that manual therapy is not a substitute for medical diagnosis and treatment. I am responsible to disclose any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: _____ Date:_____

HIPPA NOTICE

I acknowledge and agree to the following:

1. The privacy notice is available to me now and at anytime in the future.
2. Appointment reminders and newsletters may be used by the practice via email, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s):

_____ _____

Patient Signature: _____ Date:_____