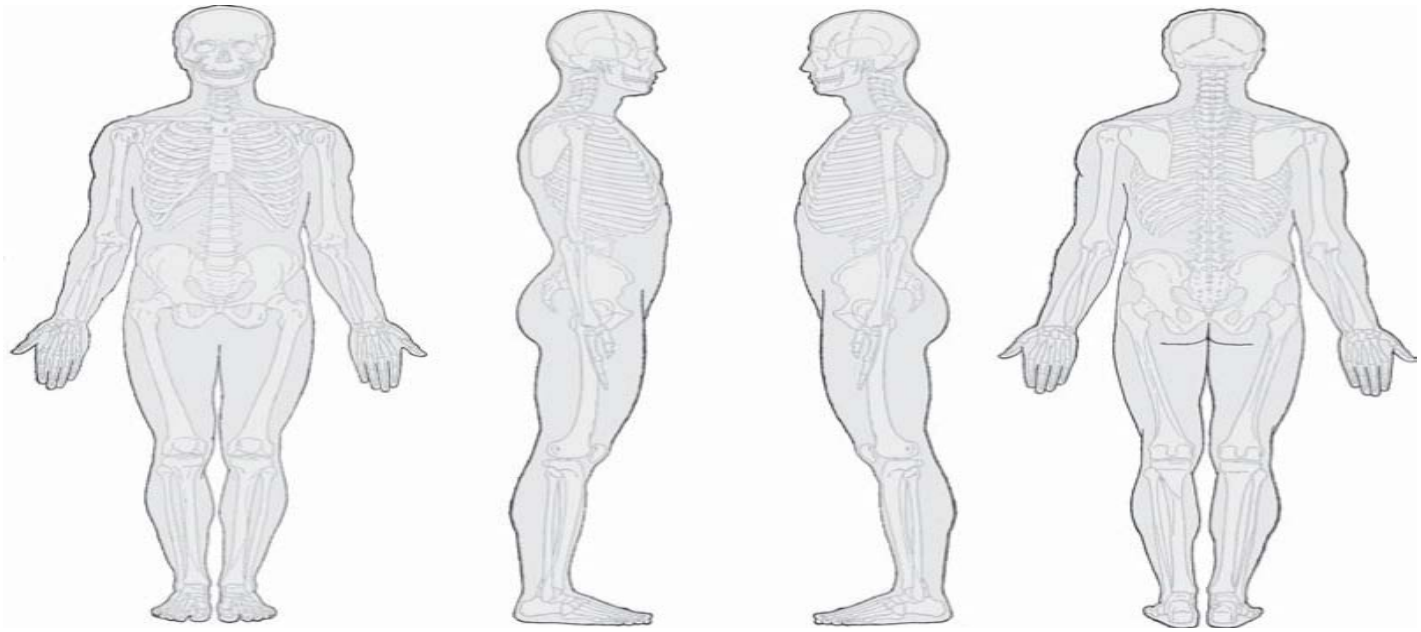
Massage Therapy New Patient Questionnaire

On the diagram below, please circle your problem areas. If you are experiencing any of the symptoms listed below, please indicate on the body chart.

KEY: **A** = ACHE **B** = BURNING **N**= NUMBNESS **S**= SHARP/SHOOTING **P**=PINS AND NEEDLES



FRONT RIGHT SIDE LEFT SIDE BACK

This hurts. . .

☐ Constantly (76-100% of the day) ☐ Severely (51-75%) ☐ Moderately (26-50%) ☐ Slightly (0-25%)

Since your symptoms began, the pain is:

☐ Increasing ☐ Decreasing ☐ Not changing

What increases your symptoms?

☐ Nothing ☐ Laying down ☐ Inactivity ☐ Walking ☐ Moving/exercise ☐ Standing ☐ Sitting

☐ Other_____

Grade Your General Stress Level: ☐ No stress ☐Minimal ☐ Moderate ☐Greatly stressed

Physical Activity at Work: ☐ Sedentary 50% of day ☐ Light manual labor ☐ Manual labor

General Physical Activity: ☐ No regular exercise ☐ Light Exercise ☐Strenuous

Are your current symptoms affecting your ability to work or be active?

☐ No effect--this does not hurt at all at work or at home

☐ Some physical restrictions--it hurts, but I am able to perform light duty work and household tasks

☐ Need limited assistance with common everyday tasks due to pain or inability to function

☐ Need assistance often due to pain

☐ Have a significant inability to function without assistance due to pain

Please check the boxes that apply for you, both past and present:

PAST	PRESENT	PAST	PRESENT
☐	☐ Fainting/visual disturbances	☐	☐ Chronic Fatigue
☐	☐ PMS- severe	☐	☐ Chronic sinusitis
☐	☐ Chronic cough	☐	☐ Loss of bladder or bowel control
☐	☐ Abdominal pain	☐	☐ Constipation/irregular bowel habit
☐	☐ Difficulty in swallowing	☐	☐ Heartburn/indigestion
☐	☐ Swelling/stiffness of joints	☐	☐ Dermatitis/eczema/rash
☐	☐ Nausea	☐	☐ Pregnancy
☐	☐ Convulsions	☐	☐ Tobacco use _____packs per day
☐	☐ Dizziness		for the past _____ years
☐	☐ Muscular in-coordination	☐	☐ Alcohol use
☐	☐ Tinnitus (ear ringing)	☐	☐ Drug or alcohol dependence
☐	☐ Rapid heart- beat	☐	☐ Caffeinated beverage _____ per day
☐	☐ Chest pains	☐	☐ Medications (list them) _____
☐	☐ Loss of appetite		_____
☐	☐ Broken Bones _____		
☐	☐ Weight change (gain) (loss)_____lbs. Intentional weight change? ☐ yes ☐no		

What are your objectives in seeking Massage Therapy treatment? (What are your expectations?)

What, if any other steps have you taken to solve this problem? (Acupuncture, Physical Therapy, etc.)

How did this pain or problem begin?

Have you been injured? Been in a car accident? Been Hospitalized? Surgeries? (List with dates of incidence)

List any family history of major illness and premature death such as, diabetes, cancer, arthritis, heart disease, asthma. . . who in your family had them?

List any disease or disorder that you presently have, if any; such as, diabetes, depression, high blood pressure, cancer, …

Signature _____ Date_____

Potter Chiropractic & Wellness Center

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PROTECTED HEALTH INFORMATION CONSENT FORM (HIPPA)

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you ask.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations, massage and coordination of care as an example. The patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum need for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. The patient understands and agrees to allow this office to use their name for newsletters (both mailed and emailed), birthday cards, patient testimonials, referrals, appointment reminder calls and/or mailings, reactivation calls and/or mailings, etc.

Client's Initials _____

Massage Therapy Informed Consent

I understand that massage therapy provided by a trained massage therapist at Potter Chiropractic is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. The general procedure has been explained to me and I understand that massage therapy is not a substitute for medical treatment or medications. I understand that it is recommended that I concurrently work with my primary caregiver for any conditions I may have. I am aware that the massage therapist does not diagnose illnesses or diseases, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage therapist of all my known physical, mental, and medical conditions, and medications, and I will keep the massage therapist updated on any changes. I do not have any infectious diseases, and I have informed the massage therapist of any history of infectious diseases. I understand that there shall be no liability on the massage therapist or Potter Chiropractic due to my forgetting to relay any pertinent information. I will be open and honest with the massage therapist and express any pain or discomfort that I experience during the massage so that treatment can be adjusted. I will respect my massage therapist and remain draped appropriately. I understand that if I no show to my appointment without calling, I will be charged on the third occurrence. By signing, I understand and agree to these conditions.

I understand both the Massage Therapy Informed Consent as well as how my PHI will be used (HIPPA).

Client's Signature_____Date _____

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CONFIDENTIAL PATIENT INFORMATION

Name_____ Middle initial _____

Birth Date:____/_____/_____ What do you prefer to be called?_____

Address_____City_____ Zip Code_____

Home Phone (_____) _____Work Phone (_____) _____

Cell Phone(_____) _____ Email:_____

Employer_____Occupation_____

Work Address_____

Marital Status ☐Married ☐Single ☐Divorced ☐Widowed

Spouse's Name_____ # of children _____ Names/Ages:_____

How did you hear about Potter Chiropractic & Wellness Center?_____

Dear Patient,
The mission of Potter Chiropractic & Wellness Center is to provide our patients with the highest quality health care by accurately diagnosing and correcting the Vertebral Subluxation Complex. We are committed to providing our patients with ongoing health education, empowering them with the information necessary to make effective and informed decisions about their current health concerns and how to reach a state of optimum health. We attract patients who are committed to improving, achieving and maintaining optimum health for themselves, their families, friends, and our community. Our patients refer others enthusiastically, out of their understanding of chiropractic and knowing our commitment to their health and well being. When I established this practice, I named it a Wellness Center to show my dedication to 'well care'. I believe that it is easier to help you *stay* well than to *get* well. Wellness care is more cost effective! However, if you choose to utilize your **insurance** I will assist you every step of the way.

Insurance does NOT pay for Massage