justice family chiropractic

MASSAGE PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Cell Phone: ( ) _____

City, State, Zip: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

INSURANCE INFORMATION

Primary Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Secondary Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Is this condition due to a work injury or motor vehicle accident? Yes No

PURPOSE(S) OF THIS VISIT

1. Have you had a professional massage before? Yes No
   If yes, how often do you receive a massage? _____
2. Do you have any difficulty lying on your front, back or side? Yes No
   If yes, please explain: _____
3. Do you have any allergies to oils, lotions or ointments? Yes No
   If yes, please explain: _____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses (Y/N) dentures (Y/N) a hearing aid (Y/N)
6. Do you sit for long hours at a work station, computer or driving? Yes No
   If yes, please describe: _____

7. Do you perform any repetitive movement in your work, sports or hobby?

   If yes, please explain: _____

8. Do you experience stress in your work, family or other aspect of your life? Yes No

   If yes, how do you think it has affected your health? _____

   Muscle tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other: _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify: _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain: _____

MEDICAL HISTORY

In order to plan a massage session that is safe and effective, please complete the following information:

11. Are you currently under medical supervision? Yes No

    If yes, please explain: _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medication? Yes No

    If yes, please list: _____

14. Please check any condition listed below that applies to you:

☐ Contagious skin condition	☐ Phlebitis
☐ Open sores or wounds	☐ Deep vein thrombosis/blood clots
☐ Easy bruising	☐ Joint disorder/rheumatoid arthritis/ osteoarthritis/tendonitis
☐ Recent accident or injury	☐ Osteoporosis
☐ Recent fracture	☐ Epilepsy
☐ Recent surgery	☐ Headaches/migraines
☐ Artificial joint	☐ Cancer
☐ Sprains/strains	☐ Diabetes
☐ Current fever	☐ Decreased sensation
☐ Swollen glands	☐ Back/neck problems
☐ Allergies/sensitivity	☐ Fibromyalgia
☐ Heart condition	☐ TMJ
☐ High or low blood pressure	☐ Carpal tunnel syndrome
☐ Circulatory disorder	☐ Tennis elbow
☐ Varicose veins	☐ Pregnancy If yes, how many weeks? _____ Due date? _____
☐ Atherosclerosis	

Please explain any condition that you have marked above:

_____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

FINANCIAL INFORMATION

I understand that all services rendered are my financial responsibility. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. Justice Family Chiropractic will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. I also understand that if my insurance company requires pre-authorization of services or review of medical notes, that Justice Family Chiropractic will provide required documentation to my insurance company but I am financially responsible if my insurance chooses not to cover rendered services. Any monies received will be credited to my account. I certify that if this office visit is related to any personal injury or worker's compensation case that is active or that has not been closed I have noted this above.

Signature_____ Date _____
(If under age 18) Parent's signature

Due to the extensive wait list for massage therapy, I understand that Justice Family Chiropractic will impose a $20 cancellation charge on all appointments not cancelled or rescheduled at least 24 hours prior to appointment.

Signature_____ Date _____
(If under age 18) Parent's signature

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1) The right to review the notice prior to signing this consent,
2) The right to object to the use of my health information for directory purposes, and
3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Justice Family Chiropractic and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: Date:

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____