SPINE & EXTREMITIES CENTER

# MASSAGE INTAKE FORM

Today's Date: _____ Referred by: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Age: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

**Have you ever experienced a massage before?** □ Yes □ No If yes, how long ago: _____

**What kind of pressure do you prefer?** Circle one: **Light** **Medium** **Deep**

If your pressure preference changes depending on the area being treated, please describe: _____

_____

**Do you have any allergies or sensitivities**? □ Yes □ No If yes, please list: _____

_____

**Are you currently taking any medications**? □ Yes □ No If yes, please list: _____

_____

_____

**Are you currently taking any aspirin, ibuprofen, minerals, herbs or nutritional supplements?** □ Yes □ No

If yes, please list: _____

**Women only**: Are you pregnant, nursing, or planning a pregnancy? □ Yes □ No

**Have you experienced any of the following?**

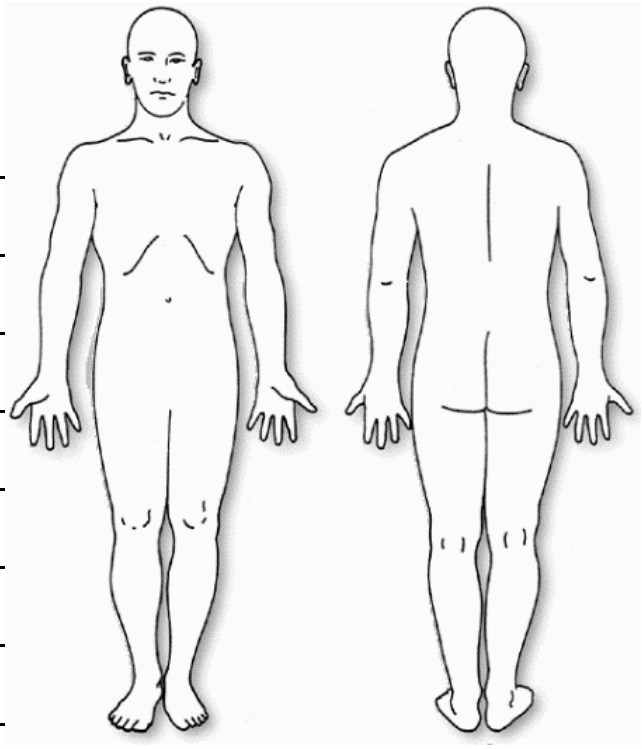
| | | | | | |
|---|---|---|---|---|---|
| High or Low Blood Pressure | □ Yes | □ No | Hormone Replacement Therapy | □ Yes | □ No |
| Seizures/Epilepsy | □ Yes | □ No | Thrombophlebitis | □ Yes | □ No |
| Stroke | □ Yes | □ No | Deep vein thrombosis | □ Yes | □ No |
| Hepatitis | □ Yes | □ No | Autoimmune disease | □ Yes | □ No |
| Easily Bruise | □ Yes | □ No | Hemophilia/bleeding disorder | □ Yes | □ No |
| Migraine headaches | □ Yes | □ No | Rheumatoid arthritis | □ Yes | □ No |
| Cancer | □ Yes | □ No | Osteoporosis | □ Yes | □ No |
| Circulatory problems | □ Yes | □ No | Aneurysm | □ Yes | □ No |
| Tumors or cysts | □ Yes | □ No | Blood clots | □ Yes | □ No |
| Diabetes | □ Yes | □ No | Complex regional pain syndrome | □ Yes | □ No |
| Fainting or dizzy spells | □ Yes | □ No | Other: _____ | | |

**Previous surgical history**: _____

_____

_____

**Please shade in areas of pain/concern:**



Notes: _____

_____

_____

_____

_____

_____

_____

_____

**Cancellation/ Late Arrival Policy**: 24-hour notice is required when cancelling an appointment. If you are unable to keep your appointment, kindly contact us as soon as possible. Failure to do so will result in the service being charged in full. If you arrive late, your session will be shortened to accommodate appointments that follow yours. Regardless of the length of the treatment, the session will be charged in full.

**Patient Consent/Liability Waiver**: Massage/ bodywork should not be performed under certain medical conditions. The information that I provided is accurate and complete. I agree to keep Spine & Extremities Center informed of any changes in my medical profile and understand that there shall be no liability on Spine & Extremities Centers' part should I fail to do so. The services I am scheduled for require person-to-person contact. By signing below, I am acknowledging this and giving permission to be treated at Spine & Extremities Center, PC. Spine & Extremities Center is not responsible for any items that you may leave unattended. We strongly recommend leaving expensive, personal items at home, or locked in your car. If you do bring them with you, be sure to gather all items from the treatment room prior to leaving.



**Patient Signature:** _____ **Date:** _____

**Staff Signature:** _____ **Date:** _____

# Spine & Extremities Center, PC (the "Company")
# Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by our Company. We may need to use your Protected Health Information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Sign Below to acknowledge that you have received a copy of our Notice of Privacy Practices:

_____ _____

Signature of patient or patient's representative | Date

_____ _____

Printed name of patient or patient's representative | Relationship to patient

Please return this acknowledgement as soon as possible. If you do not return the form in person, you may return this form by mail to our Privacy Officer at the following address:

Spine & Extremities Center
ATTN: Privacy Officer
457 S 5th Ave
Clarion, PA 16214

For use ONLY by a representative of the Company

A good faith effort was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices that was provided to (circle one) the patient/ the patient's representative on _____/_____/_____.

A signature on the acknowledgment was not obtained for the following reason(s):

_____
_____
_____
_____

Signature of Company representative:

_____

# HIPAA CONSENT FORM

FOR THE USE AND DISCLOUSURE OF PROTECTED HEALTH INFORMATION

TO OUR PATIENTS:

Patient information will be maintained by Spine & Extremities Center as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with federal and state regulation. You may obtain a copy of the Notice Of Privacy Practices by contacted the Office Manager.
Spine & Extremities Center reserves the right to release your healthcare information based upon a decision by your physician or chiropractor for medical emergency situations and in general for continuity of care. We will use your healthcare information as needed to maintain our internal operations We will release your information to anyone else that you may elect in writing to receive it.

We reserve the right to:

- Call and/or text you to remind you of your next appointment and/or leave information on your voicemail.

- Call you with lab and/or test results and leave information on your voicemail

What number would you like to be contacted? ( ) _____ - _____

If there is anyone that you would like us to share your health information with, please list the name(s) and contact information below:

_____

_____

_____



**Patient Signature:** _____ **Date:** _____

**Staff Signature:** _____ **Date:** _____