Schreiber Family
CHIROPRACTIC

Patient Information-Established Patient-Massage

Patient Name: ____ Date __________

Phone Numbers:

Home:___________________Work:____________________Cell:____________________
(Circle Primary)

Text Reminders: YES NO Cell Provider: _________________ (ex: Verizon)

By circling NO you have agreed to decline your automatic reminder for your massage appointment and will be responsible for remembering your own appointment

This text is just a helpful reminder of your appointment but does not excuse you for missing a scheduled appointment. Do not rely on the text message to be your only way of remembering your appointment.

Marital Status: Single/Married /Widowed

How did you hear about our clinic? ____

Please be as detailed as possible. Refer a friend and get your name in the monthly drawing for a FREE HOT STONE SESSION during your next massage.

What brought you here today (ex: low back pain)? ____________________________________

Patient or Guardian Signature: ___________________________________ **Date:** _________

Notice of Privacy Practice-HIPPA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The health information that you provide to us is needed for several reasons. First, it aids Jade Irlmeier, LMT in the treatment of the condition that you have presented with. Secondly, at times we share this information with third parties (i.e. lawyers, other physicians or you insurance company) in coordination of you care.
Whenever possible our office will get your permission before we disclose your health data with any other third party. Other times we may not be able to obtain your authorization prior to disclosure. Examples may be faxing/sending notes to physicians regarding upcoming appointments, filing medical claims or mailing requested forms/data to your insurance company. We will only correspond with attorneys, workers' compensation or auto insurance companies if we have received a written release of records signed by you, the patient, allowing it.

All information that you provide to us is personal and protected. We do not indiscriminately share this data and any other use not already listed will be made only with the patient's authorization. You as the patient have the right to revoke that authorization at any time.

1. You may request certain restrictions on the uses/disclosures of protected information.
2. You have the right to inspect and copy any medical information from our office.
3. Patients have the right to receive confidential communications.
4. You have the right to amend your protected information.
5. You have the right to an accounting of disclosed personal information.

Schreiber Family Chiropractic reserves the right to change this privacy policy and will provide you with a revised notice at that time.
I have read the above privacy notice and give permission for my personal information to be disclosed as listed in the above notice. I may receive a copy of this notice for my review at any time at my request.

Signature____ Date_____________

Informed Consent

This record of consent is required before the first assessment or treatment and will be maintained confidentially in the client file. It may only be released to a third party with written consent of the client.
Massage Therapy includes the assessment and treatment of the soft tissues and joints of the body, using soft tissue manipulation, joint mobilization, hydrotherapy, remedial exercises and self-care programs as determined by the therapist. Treatment plans will be discussed in advance with the client and must be agreed upon prior to start.

By signing below, the client agrees to the following:

- All massage treatments, information and records will be kept confidential and securely stored for use only by the massage therapist.
- Written consent must be given prior to any disclosure or sharing of my personal and clinical information with any third party.
- Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment.
- Draping will be used by the therapist as required to expose only the parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.
- During treatment, the therapist will endeavor to work such that a pain level of 7-8 is not exceeded, based on a pain scale of 1-10.
- If at any time during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior consent given.
- The therapist may refuse to treat any client or part of their body with just and reasonable cause.

Patient's Name (please Print) ____

Patient/Parent or Guardian Signature ____ Date ______________

Cancellation and No-Show Policy Agreement

If you are unable to keep your scheduled appointment, please call the office **24 hours** before your appointment to reschedule in order to accommodate another patient and avoid any cancellation fees.

We reserve the right to bill for your missed scheduled appointment for the following reasons at the below stated fee:

- Cancellations within 24 hours are subject to a fee of half the scheduled service charge.

- No shows will be charged the full scheduled service charge.

Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist. Full charge for the scheduled service will be expected and collected at time of service.

Fees for services are due prior to departure on the day of the treatment. Cash or personal checks are accepted. If a personal check bounces there will be an additional charge of $30.

Arriving early to your appointment ensures time for paperwork, discussing treatment and conditions and for undressing.

I, ______________________________________ (Print Name), have read and understand the information above and consent to the Massage Cancellation and No-Show Policy Agreement.

Authorized Signature: _____________________________ Date: _______________

Massage Therapy Patient Health Questionnaire

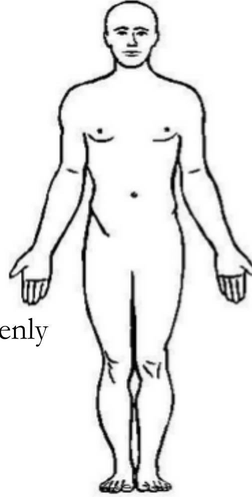
Patient Name____ Date __________________________

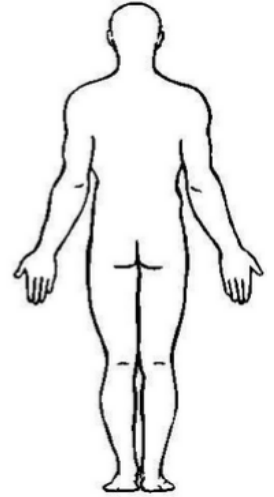
Briefly describe your symptoms or why you are seeking a Massage:

____

How did your symptoms start? ____

When did your symptoms start? ______________________ **Indicate where you have pain or other symptoms:**





What describes your symptoms?

1. Sharp 5. Tightness
2. Dull Ache 6. Throbbing
3. Numbness 7. Burning
4. Shooting 8. Tingling

How often do you have the symptoms?

1. Constantly 2. Frequently 3. Occasionally 4. Intermittenly

Have you received a massage before? YES NO

Preference on massage style:

Light 1 2 3 4 5 6 7 8 9 10 Aggressive

List any Allergies: __________________________________

List any Surgeries: ____

Please Circle if you are you currently on any: **Blood Thinner Medication and/or Blood Pressure Medication**

Please mark an (X) by any current or past conditions.

_ Abdominal/digestive	_ Circulatory/Heart	_ High Blood Pressure	_ Tension/Stress
_ Allergies	_ Constipation/Diarrhea	_ Muscle/Joint Pain	_ Vistion Problems
_ Anxiety	_ Depression	_ Numbness/Tingling	_ Varicose Veins
_ Arthritis	_ Diabetes	_ Rash	_ Other
_ Asthma	_ Fatigue	_ Sinus Problems	________________
_ Blood Clots	_ Headaches/Migraines	_ Spinal Disorders	
_ Chronic Pain	_ Hernia	_ Sprain/Strain	

Are you currently Pregnant? YES NO How far along? __________________ Due Date? ________

Patient signature: ____ Date: ____________________

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