ABOUT THE PATIENT

Health and Healing Family Chiropractic.

Name _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ❑ M ❑ F

Your Email _____ Type of Work _____

Emergency Contact _____ ph # _____ Have you had a massage before? ❑ No ❑ Yes

HEALTH INFORMATION

If you answer "yes" to any of the following questions, please explain.

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Are you wearing contact lenses?
❑ Yes ❑ No Are you wearing dentures?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No If "yes" to previous question, are you taking medication for this?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you suffer from joint swelling?
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have a contagious disease?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Have you had any broken bones in the past two years?
❑ Yes ❑ No Have you been in a collision or suffered any injuries in the past two years?
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you have tension or soreness in a specific area? Please specify: _____
❑ Yes ❑ No Do you suffer from neck pain or back pain?
❑ Yes ❑ No Do you have numbness, tingling or sharp pains anywhere?
❑ Yes ❑ No Are you very sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery? _____
❑ Yes ❑ No Do you have any other medical conditions or are you taking any medications I should know about?

Preferred Pressure:

❑ Light

❑ Moderate

❑ Deep

Comments: _____

- I understand that the massage/bodywork I receive is provided for relaxation and relief of muscular tension.
- I will immediately inform the practitioner if I experience any pain or discomfort, so that the pressure and/or strokes may be adjusted.
- I understand that the massage/bodywork should not be construed as a substitute for medical diagnosis or treatment.
- I affirm that I have stated all my known medical conditions.
- I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
- I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of this session.
- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- Person responsible for this account if other than the patient? _____
- For my balance my preferred method of payment is: ❑ Cash ❑ Check ❑ Credit Card

Patient / Parent Signature Date

Health & Healing Family Chiropractic

MASSAGE THERAPY GIFT CERTIFICATE POLICY

Health & Healing Family Chiropractic's policy is that you must present your massage gift certificate prior to receiving service. If you do not have your gift certificate with you at the time of your appointment, you will be required to provide alternative payment for that massage. You will be able to utilize your gift certificate at another appointment time.

MASSAGE SCHEDULING AND CANCELATION POLICY

If you are unable to make it to your massage appointment, we require you to cancel at least 24 hours prior to your appointment. We require a credit card number on file prior to scheduling a massage appointment. If 24 hours is not given, we will try to fill your massage appointment, but if we are not able to, your credit card will be charged for the full fee of the original massage price or if you are a massage club member a massage will be forfeited. Massage fees that will be charged is as follows: 90 minute $117.94, 60 minute $85.70, and a 30 minute $48.21.

Credit Card # _____ Exp Date _____

Gratuity is always welcome but never required. Gratuity must be paid directly to your therapist in cash, check or Venmo.

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is very important to us. Disclosure of your protected health information with out authorization is strictly limited.

I understand that under the HIPPA Act of 1986, I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:
1-Conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in my care directly or indirectly; 2-Obtain payment from third party payers; and 3Conduct normal healthcare operations. Any other disclosures for the purpose of care, payment or practice operation will be made only after obtaining your consent.

A full copy with a more complete description of the privacy practices can be requested. I also understand that I may request, in writing, that you restrict how my personal information is used and or disclosed.

I have read and understand Health & Healing Family Chiropractic CANCELLED AND MISSED APPOINTMENT POLICIES and NOTICE OF PRIVACY PRACTICES.

Print Name_____ Signature _____

Date _____ Relationship if Patient is a Minor_____