Massage Intake Form--CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name:			Date of Birth:	
Address:			Email:	
City:	State:	ZIP:	Home Phone:	
Occupation:			Work Phone:	

Have you ever received massage therapy? _____Yes _____No

Type of massage experienced (Swedish, shiatsu, deep tissue, etc.)_____

Are you currently taking medications? _____Yes _____No

If yes, please list name and reason for medications.

_____

_____

Are you currently seeing a healthcare professional? _____Yes _____No

If yes, please list names and reasons/treatment.

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

____	arthritis	____	depression, panic disorder, other psych conditions	____	hepatitis (A,B,C, other)
____	diabetes	____	diverticulitis	____	skin condition
____	blood clots	____	headaches	____	stroke
____	broken/dislocated bones	____	heart conditions	____	surgery
____	bruise easily	____	back problems	____	TMJ disorder
____	cancer	____	high blood pressure	____	Seizures
____	chronic pain	____	Insomnia	____	Scoliosis
____	constipation/diarrhea	____	muscle strain/sprain	____	
____	Whiplash	____	Chemical Dependency	____	

*AIDS, fibromyalgia, chronic fatigue, lupus, etc.

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____

Stewart Health

Health Self-Assessment

Name_____. Date_____.

How would you describe your own health?	Circle One for Each Question			
I think my health is	Very Good	Good	Fair	Poor
Sometimes I feel much older than I really am.	Yes		No	
I have trouble falling asleep.	Often	Occasionally	Almost Never	
I usually get plenty of sleep.	Yes		No	
Sometimes my mind feels "foggy" around the edges.	Yes		No	
Headaches	Yes		No	
I get hit by the "Mid-Day Crash" and need a "boost" to keep going.	Yes		No	
My tummy gives me trouble, even when I eat right.	Yes		No	
I seem to catch whatever is "going around."	Yes		No	
My Joints are achy and stiff.	Often	Occasionally	Almost Never	
I am concerned about how healthy my heart might really be.	Yes		No	
I have Type-II diabetes or hyperglycemia.	Yes		No	
I have been diagnosed with a degenerative disease (other than these). Describe:_____	Yes		No	
I have difficulty keeping my balance.	Yes		No	
I eat at least 9 servings of organic fruits and vegetables every day.	Yes		No	
I drink at least 2 liters of water every day.	Yes		No	
I feel that my weight is something that I would like to be addressed.	Yes		No	

Other thoughts about my personal health and wellness:

_____

_____

_____

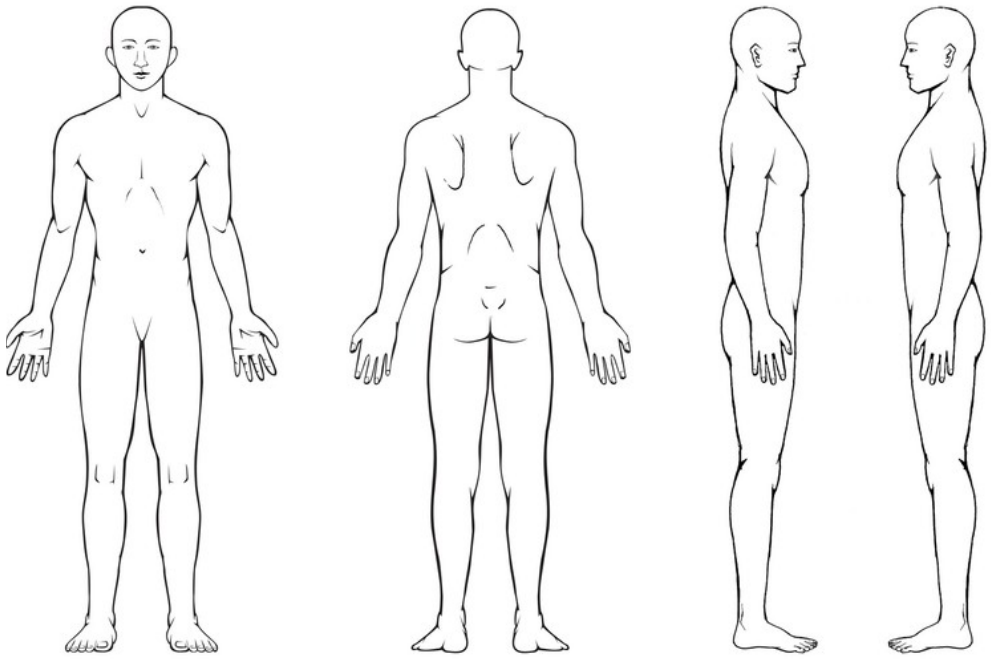
Thank you for taking the time to complete this form. My goal is to do all I can to help you achieve the level of health and wellness you would love to have.

Do you have any of the following today:
____skin rash ____cold/flu _____ open cuts ____severe pain _____ anything contagious _____ injuries/ bruises

Do you have any allergies to:
____medications _____ foods (nuts, etc.)
_____ environmental allergens (dust,pollen, fragrances) _____ reactions to skin care products

If any of the above are checked, please give details:_____
_____
_____

Are you wearing: _____ contact lenses _____ hearing aid _____ hairpiece



Please mark your scars/tattoos above.

What are your goals/expectations for this therapy session?_____
_____
_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position—sighing, yawning, change in breathing, stomach gurgling—emotional feelings and/or expression—movement of intestinal gas—falling asleep—memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature:_____**Date:**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose you health information.

If you sign a consent form, we may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice. Examples are quality assessment and improvement activities, audits, cost-management analysis, and customer service reviews.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.

Any other useless and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except tot the extent that we have already take actions relying on your authorization.

You have the following right with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it until you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information form us by alternative means or at her native locations.
- The right to inspect and copy your protected health information.

I, _____(print name) have received a printed comply and understand my rights relating to the privacy practices guaranteed by the Health Insurance Portability & Accountability Act of1996 ("HIPAA").

Signature: _____ Date: _____

Stewart Health

Vancouver, WA 98661
360-281-5168

CANCELLATION POLICY

We are pleased that you have chosen us to become part of your health care team by providing Therapeutic Massage Therapy. We are sure that you understand that when we reserve this amount of time specifically for your therapy session that difficulties occur when you are unable to keep your reservation. Reluctantly out of necessity, there is a cancellation policy for your massage appointments. It is as follows:

1. **Except in the case of illness or emergency, you will be financially responsible for payments of missed appointments if not cancelled at least six(6) hours in advance. Missed or cancelled appointments without six(6) hours notice will be charged $30 for the missed session.**
2. **If you are late for an appointment, treatment time will be extended if possible. If time can not be extended you will still be charged for a full session.**

Please take a moment to carefully read the following information and sign where indicated.

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis of treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of . I understand that massage practitioner's are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. Because therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. 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 forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment.

Signature_____. Date_____.