Hand to Hand
FITNESS

PATIENT INTAKE FORM

Date: _____

Last Name _____ First Name _____ MI ____

Date of Birth____/____/____

Address _____ City _____
State _____ ZIP _____

Phone (_____) _____ - _____

Please give the name and phone number of anyone you want contacted in case of an Emergency

Last Name _____ First Name _____

Relation to you _____

Phone (_____) _____ - _____

Occupation _____

Occupational concerns related to massage (Work activities that may affect your condition)

Propensus Massage

ACCIDENTS, INJURIES, OR SURGERIES

More Than 5 Years Ago.:

_____

Less Than 5 Years Ago:

_____

Are you receiving any other kind of medical treatment? No ☐ Yes ☐ If Yes, please briefly explain:

_____
_____
_____
_____

Check those which you consume:

☐ Alcohol ☐ Caffeine ☐ Cigarettes ☐ Recreational Drugs

Please check where you would rate your level of physical activity:

☐ Light ☐ Moderate ☐ Heavy

Do you exercise? _____

What type? _____

Propensus Massage

CHECK ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE LAST 3 MONTHS.

- ☐ Allergies
- ☐ Arthritis
- ☐ Back Pain
- ☐ Broken Bones
- ☐ Bursitis
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Colitis
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive Problems
- ☐ Disc Problems
- ☐ Diverticulitis
- ☐ Epilepsy/Seizures
- ☐ Excess Stress
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Herpes Virus
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Muscle Spasms
- ☐ Numbness
- ☐ Phlebitis
- ☐ Psoriasis
- ☐ Rashes
- ☐ Sciatica
- ☐ Skin Allergies
- ☐ Sprains/Strains
- ☐ Stiff Joints
- ☐ Stroke
- ☐ Swollen Feet
- ☐ Tendinitis
- ☐ Tingling
- ☐ Tumors
- ☐ Varicose Veins
- ☐ Whiplash

Please check if you are currently experiencing any of the following conditions:

- ☐ Contagious disease
- ☐ Fever
- ☐ Flu or Cold
- ☐ Infection
- ☐ Inflammation
- ☐ Pregnancy

Have you had any Lymph nodes removed due to surgery of any kind? Please describe:

_____

_____

Name: _____ Date: _____ Form 10/2019

Propensus Massage

HISTORY OF PRESENT AILMENT

What is/are the ailment/s you are here about?

_____

_____

When did this ailment first become apparent?

_____

_____

Is the ailment constant or intermittent? _____

Are there any other related symptoms? (Headache, Insomnia, Nausea, Etc.)

PLEASE READ AND SIGN

I acknowledge that the above information is complete and accurate to the best of my knowledge. I clearly understand that massage therapy treatments are my personal financial responsibility, and I agree to pay for these services at the time of treatment, unless other arrangements have been made. I understand that I may be charged for any appointment broken with less than 24 hours' notice.

Patient Printed Name _____

Patient Signature _____ Date _____

Propensus Massage

Informed Consent for Massage Therapy

Nature of Massage therapy: Your treatment may include table massage, floor massage, traction, jostling, passive movement, resistive movement, natural lubricants, heated rocks or packs, ice and salt or clay applications. Any and all of these treatments may be offered at no extra cost to you as deemed necessary.

Purpose of Massage therapy: The purpose of the treatment is to create a state of relaxation within your mind and body then work within my scope of practice to promote a healing response in your body. As with any form of health care, there is no guarantee regarding the outcome of any course of treatment.

Benefit of Massage therapy: Massage has been a primary medical modality for thousands of years. Hippocrates who is considered one of the most outstanding figures in the history of medicine and often referred to as the Father of medicine stated that, "Healing begins with an aromatic bath and daily massage" and, "anyone wishing to study medicine must first master the art of massage." …"For rubbing can bind a joint that is too loose and loosen a joint that is too rigid." Massage has been clinically proven to be beneficial for a myriad of ailments.

Risks of Massage therapy: Of course, your therapist is unable to anticipate or explain all risks and complications that may occur during or after a treatment. Your therapist will exercise judgment based upon his determination of your best interests. There are some uncommon, but potential risks. These potential risks may include, but are not limited to: • discomfort during and after massage • localized, minor bruising or swelling • temporary brain fog after the massage (due to extreme relaxation)• Feelings of elation or juxtaposed, feelings of anxiety, usually due to a past trauma resurfacing.• Worsening of condition

Special Situations: Some massage therapy techniques are contraindicated during pregnancy. Please notify your practitioner if you are or might be pregnant. Additionally, you need to inform your practitioner if you have any condition that may put yourself or your therapist at risk

Propensus Massage

Consent

I , _____ request and consent to the performance of massage therapy. I understand that I am free to withdraw my consent, and that I may stop treatment or any procedure at any time. I understand that my signature on this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I may ask questions and or consult an attorney. I hereby release James Vanwert from any and all liability that may occur in connection with the above- mentioned modalities, except for failure to perform massage therapy in a safe and ethical manner.

Patient's Name (Please Print) _____ Date_____

Patient's Signature _____

Propensus Massage

Notice of Privacy Practices

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.

HIPAA 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, on 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. HIPPA provides penalties for covered entities that misuse personal health information.

MY PLEDGE REGARDING YOUR MEDICAL INFORMATION I respect my legal obligation to keep health information that identifies you private and double locked. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situation, the law requires me to disclose your health information without either a written or verbal consent.

USE AND DISCLOSURE WITH CONSENT INFORMATION I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

• Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.

• Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I are required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

USE AND DISCLOSURE WITHOUT CONSENT In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

• When a state or federal law mandates that certain health information be reported for a specific purpose.

• For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.

• Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.

• Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.

• Disclosures in response to subpoenas or orders of the court.

• Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.

• Disclosure related to worker's compensation programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights 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 the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.

• The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.

• The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc). Please complete my written records request for billing or medical record release.

• The right to receive an accounting of disclosures of protected health information.

• The right to amend your protected health information.

• The right to obtain a paper copy of this notice from me upon request.