WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Name _____ Sex M /F Date_____

Address _____City_____ State_____ Zip_____

Home Phone _____Cell Phone_____ Date of Birth _____

Age_____

How did you hear about us _____

Email_____

Would you like to pay with: Insurance (please give front desk your card) OR out of pocket (Circle one).

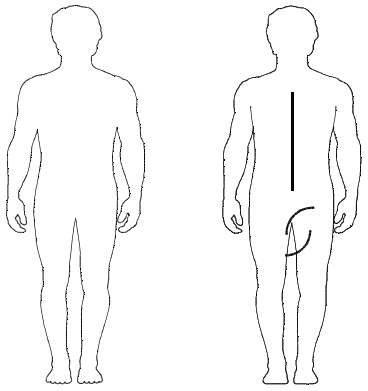
Is this an Auto Accident or Work Comp related injury? (circle): Insurance/claim #: _____

Date of Accident or injury (if applicable): _____

1. Where is your pain/problem located? Write in words or use the picture to show where you have pain.

   _____

   _____



2. Circle the word(s) that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

3. *Does your pain occur occasionally, frequently or is it constant? (Circle one)*

   Occasionally Frequently Constant

4. *What time of day is your pain the worst? (Circle one)*

   Morning Afternoon Evening Nighttime

5. *Rate your pain by circling the number that best describes your pain at its **worst** in the last month.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. *Rate your pain by circling the number that best describes your pain at its **least** in the last month.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. Rate *your pain by circling the number that best describes your pain on* ***average*** *in the last month.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

8. *What makes your pain* ***better***? _____

9. *What makes your pain* ***worse***? _____

10. *What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.*

    None

    _____

Past Health History:

A. Previous illnesses/conditions you've had in your life:

(Gender assignment at birth may impact investigation of current health issues)

❑ Diabetes ❑ Cancer ❑ Stroke ❑ Arthritis ❑ Seizures ❑ Ulcers ❑ AIDS/HIV ❑ Joint Replacement ❑ Glaucoma

❑ Hepatitis ❑ Anemia ❑ Alcoholism ❑ Lung Disease ❑ Heart Disease ❑ Diverticulitis ❑ Pacemaker ❑ Kidney Disease

❑ Thyroid Disease ❑ Tuberculosis ❑ Hypertension ❑ Blood Thinners ❑ Depression ❑ Anxiety

❑ Other_____

B. Surgeries/Hospitalizations/Injuries/Fractures/Dislocations: (Please provide Month/Year)

_____

C. Allergies _____

D. Current Medications/Supplements: _____

E. Conditions you are taking medications for: _____

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INFORMED CONSENT FOR MASSAGE THERAPY

I hereby request and consent to the performance of massage therapy by the therapist/technician of Whitaker Wellness / Powell Valley Chiropractic Clinic. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. I understand that massage therapists/technicians do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination and I will seek health care for those services. I accept that massage promises no long-term results nor will it cure my health problems.

The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.
Although massage therapy is extremely safe there are some risks and side effects which include: soreness, fatigue, allergic reaction to lotions, bruising/internal bleeding (if on blood thinner medication), and release of blood clots (increased risk with people who have deep vein thrombosis).

If at any time during the massage the client or therapist/technician is uncomfortable for any reason, they shall immediately say so.
Sexual advances of any kind will not be tolerated.
Cancellation Policy: A 24-hour notice is required for cancellation of your massage appointment.
All information will be kept strictly confidential and will remain with Whitaker Wellness / Powell Valley Wellness.

I have read and agree with above information. If I have any questions or concerns, I will let the therapist know right away.

Patient Name: _____

Signature of Patient (Guardian if a minor): _____

Parent Name (If Minor): _____

Date:_____

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Patient Authorization Form

I have had the **Notice of Privacy Practice** made available to me and have had the opportunity to review its contents prior to signing this authorization.

I authorize the use of my medical information according to the **Notice of Privacy Practice**.

I authorize the release of any medical information necessary to process my claim.

I authorize the following individual(s) (family, spouse, friends) access to information about my medical records and appointments at **Whitaker Wellness / Powell Valley Wellness**:

Name(s): _____

I authorize **Whitaker Wellness / Powell Valley Wellness** to send text message reminders about my appointments and to leave a message whenever they need additional information from me.

- ☐ Check box if you want to **OPT OUT** of voicemails.
- ☐ Check box if you want to **OPT OUT** of text message reminders.
- ☐ Check box if you want to **OPT OUT** of Email reminders.

I authorize payment of medical benefits to **Whitaker Wellness / Powell Valley Wellness**

I authorize the release of information to any other entity for which I have signed a release.

I authorize **Whitaker Wellness / Powell Valley Wellness** to release information to any entity that I personally instruct them to release information to.

We, at **Whitaker Wellness / Powell Valley Wellness**, will gladly bill your insurance company. However, the full responsibility for payment of all professional services belongs to you, the patient.

If you do not have insurance or choose not to use your insurance, we do offer a Time Of Service Discount (TOSD) here. The TOSD will give you discount on your treatments here. You can use the TOSD for any service offered here. Pricing is dependent on the services performed. Please ask the front desk for specific pricing. **In order to qualify for the TOSD you have pay for your services the day of visit. If you do not pay the same day you were seen then you do not qualify for the TOSD and must pay full pricing.**

_____ _____

Patient Name Date

_____ _____

Patient Signature (Parent Signature if minor) Parent Name (If Minor)

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Cancellation Policy/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

If any appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

_____ _____

Patient name Date

_____

Signature Patient/Guardian