



Massage Therapy

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).

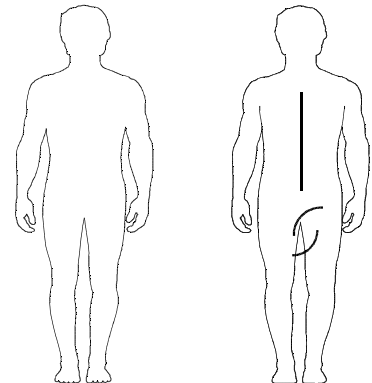
Is this an Auto Accident or Work Comp related injury? (circle): Insurance/claim #: _____

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: _____



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 **Do Not** approve voicemails when we have questions.
☐ Check box if you **Do Not** want text message reminders.
☐ Check box if you **Do Not** want 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 set pricing on your treatments here. You can use the TOSD for chiropractic, massage, and/or primary care. 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.

We reserve the right, at our sole discretion, to charge a no show/late cancellation fee of \$50.00 per occurrence for missed appointments or appointments canceled less than 24 hours of their scheduled time and date. This will be deducted from any reimbursements made to the patient. If you have a Card on file you authorization us to charge that card.

Patient Name

Date

Patient Signature (Parent Signature if minor)

Parent Name (If Minor)



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: _____

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