PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ Date:_____Referred by: _____

Address: _____ Home Phone #: _____

City, State, & Zip: _____Work/Cell Phone#: _____

Date of Birth:_____Occupation: _____Employer: _____

Email:_____Primary Care Physician: _____

MASSAGE/TREATMENT HISTORY

Have you ever received a professional massage? ☐ Yes Date of last massage: _____ ☐ No

What results do you want from your massage sessions? _____

_____

What areas of your body would you like the therapist to focus on?

_____

Are there any areas of your body that you would not like to have worked on?

_____

Are you currently under the care of a medical practitioner? ☐Yes ☐No If yes, please explain:

_____

Please list stress reduction and exercise activities: _____

Please list any medications you are taking, including over-the-counter drugs (such as: aspirin, ibuprofen, etc): _____

Any allergies? _____

Please list any previous surgeries, injuries, and/or accidents, including year and any treatment received:

_____

_____

HEALTH HISTORY Please check all that apply, specifying past or current and the location.

MUSCULO-SKELETAL

Past	Current		Past	Current	
☐	☐	Bone or joint disease _____	☐	☐	Jaw pain, TMJ _____
☐	☐	Neck, shoulder, arm pain _____	☐	☐	Arthritis _____
☐	☐	Tendonitis _____	☐	☐	Lupus _____
☐	☐	Headaches, head injuries _____	☐	☐	Sprain(s)/Strain(s) _____
☐	☐	Bursitis _____	☐	☐	Low back, hip, leg pain _____
Past	Current		Past	Current	
☐	☐	Spasm(s)/Cramp(s) _____	☐	☐	Broken/Fractured bones _____
☐	☐	Fibromyalgia _____	☐	☐	Other _____

CIRCULATORY/RESPIRATORY

Past	Current		Past	Current	
☐	☐	Heart condition	☐	☐	Rashes
☐	☐	Varicose veins	☐	☐	Eczema/Psoriasis
☐	☐	Blood clots	☐	☐	Warts
☐	☐	High/Low blood pressure	☐	☐	Open wounds/Bruises
☐	☐	Thrombophlebitis	☐	☐	Athletes' foot/Fungal infection
☐	☐	Lymphedema	☐	☐	Other
☐	☐	Breathing difficulty	DIGESTIVE/URINARY		
☐	☐	Sinus problems	☐	☐	Constipation/Gas/Bloating
☐	☐	Other	☐	☐	Cirrhosis
NERVOUS			☐	☐	Irritable bowel syndrome
☐	☐	Numbness/Tingling	☐	☐	Diverticulitis
☐	☐	Herpes/Shingles	☐	☐	Renal failure
☐	☐	Multiple Sclerosis	REPRODUCTIVE		
☐	☐	Chronic pain	☐	☐	Pregnancy: Stage
☐	☐	Sleep disorder	☐	☐	PMS
☐	☐	Fatigue	☐	☐	Endometriosis
☐	☐	Seizure disorder	☐	☐	Other
☐	☐	Other	OTHER		
		INFECTIOUS DISEASE	☐	☐	Cancer/Tumor(s)
☐	☐	Disease name/description	☐	☐	Auto-immune disorder
			☐	☐	Diabetes
☐	☐	Disease name/description	☐	☐	Eating disorder
			☐	☐	Depression

ADDICTION(S)

Past	Current		Past	Current		Past	Current		Past	Current	
☐	☐	Drug(s)	☐	☐	Alcohol	☐	☐	Nicotine	☐	☐	Caffeine

It is my choice to receive massage therapy and I realize the treatment is being given for the well being of my body and mind. This can include relief from muscular tension, spasm or pain, stress reduction or for increasing circulation and energy flow. I agree to communicate with my practitioner if, at any time, I feel that my well-being has been compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; not do they prescribe medical treatment or pharmaceuticals or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions of which I am aware and will update the massage practitioner of any changes to my health status.

SIGNATURE: _____ **DATE:** _____

Maple Valley Chiropractic & Massage, P.S.
Ryan Donovan, D.C.

23220 Maple Valley Black Diamond Rd SE, Ste 13
Maple Valley, WA 98038

Phone: (425)432-1449
Fax: (425)432-9910

Massage Policies and Procedures

- All our patients are required to make payment in full at the time of service unless other arrangements have been made; this includes insurance co-pays.
- If payment is **NOT** made at the time of service, you will be billed $150.00. The time of service discount of $75.00 is **ONLY** applicable if payment is made at the time of service.
- **24 hours notice is REQUIRED to avoid cancellation fee of $50.00 per missed appointment. (This fee is NOT covered by any insurance company)**
- Massages beginning late will end at the scheduled time and are charged at full price. The missed portion is not covered by insurance and will be your responsibility. If you are more than 15 minutes late, the appointment may be considered cancelled.
- Sexual harassment is **NOT** tolerated. If a therapist feels their safety is compromised, the session stops immediately and all of your massage privileges at our clinic will be revoked.
- **Underwear must be worn during your massage.**
- Due to liability issues, we request you do **NOT** bring your children to your massage appointment.
- Massage is **NOT** a substitute for seeing your primary care physician. Massage Therapists are not able to diagnose any physical or mental condition. If you feel you need a diagnosis, please consult your doctor.
- The actual hands-on portion of your session may be less than the full appointment time to provide time for a full health intake by your practitioner.
- You are a major part of your health care team. Massage is an integral **PART** of your health care plan. You agree to participate fully in your treatment plan and notify us of any changes in your health condition.
- **By signing this document, you agree to inform your practitioner of any pain or discomfort during the massage.**

Patient Name (printed): _____

Patient Signature: _____ **Date:** _____

Maple Valley Chiropractic and Massage
23220 Maple Valley/Black Diamond Rd SE, Ste 13

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

In the course of your care as a patient at Maple Valley Chiropractic and Massage, we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You can ask us not to use or share certain health information for treatment, payment, or our operations.

*We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

*We will say “yes” unless a law requires us to share that information.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Ryan Donovan.

If you would like further information about our privacy policies and practices please contact Dr. Ryan Donovan.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an “open-adjusting” environment for ongoing patient care. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

This notice is effective as of date signed below.

_____ _____ _____

Full Name (Printed) Signature Date

If you are a minor, or if you are being represented by another party:

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient