Pacific Chiropractic Clinic

7503 196th St SW, Lynnwood, WA 98036

425-775-8000

Name: _____ Date: _____

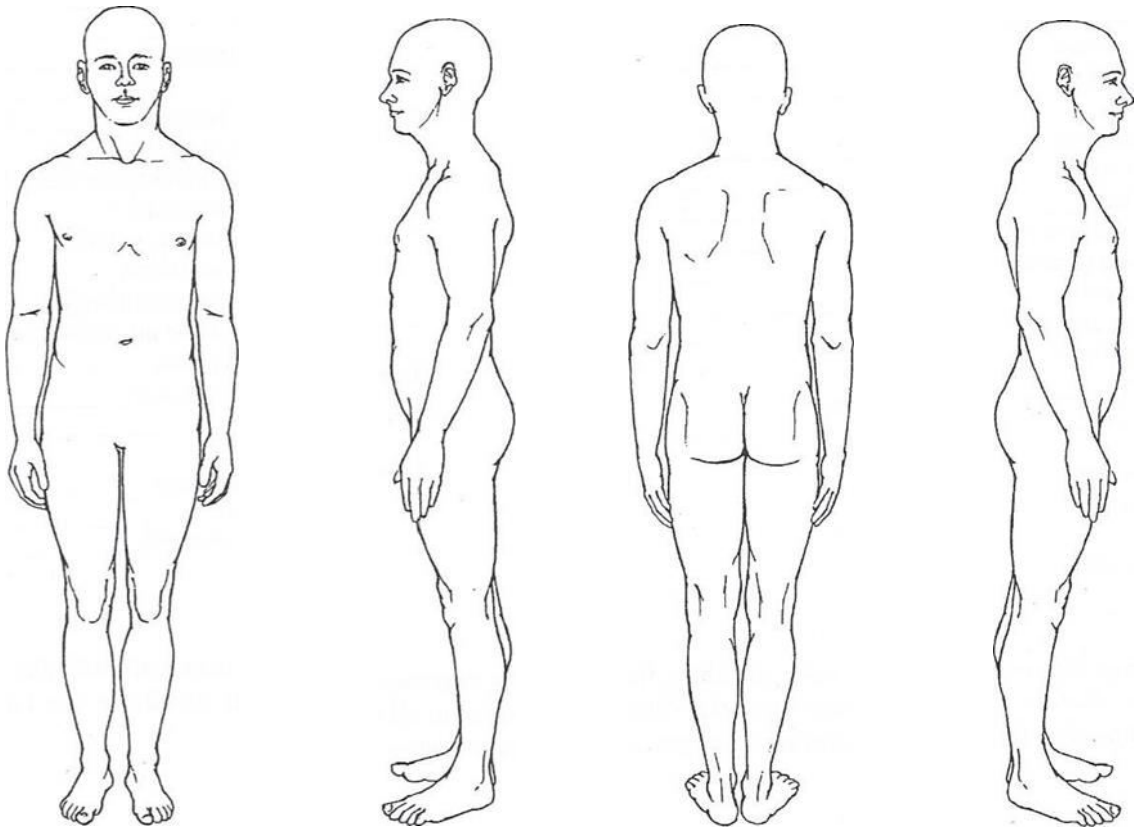
Address: _____

Phone: _____ Birthdate: _____ Emergency Contact/Phone: _____

- Draw your symptoms on the figures by using the KEY below to write the letters on the figures
- Circle the area around each letter, representing the size & shape of each symptom

KEY:

P = pain or tenderness **S** = joint or muscle stiffness **N** = numbness or tingling



Massage History/Treatment Information

List current medications, including aspirin, ibuprofen, etc. _____

_____

Health History (check which apply and explain):

Musculo-Skeletal:

__ Bone or joint disease _____

__ Tendonitis _____

__ Bursitis _____

__ Broken/fractured bones _____

__ Arthritis _____

__ Sprains/strains _____

__ Low back/hip/leg pain _____

__ Neck/shoulder/arm pain _____

__ Spasms/cramps _____

__ Jaw pain/TMJ _____

Circulatory:

__Heart condition _____

__ Stroke _____

__ Dizziness _____

__ High blood pressure

__ Low blood pressure

__ Chest pain _____

__ Breathing difficulty/asthma _____

__ Lymphedema _____

__ Allergies _____

__ Sinus problems_____

Other:

__ Cancer/tumors _____

__ Diabetes _____

Digestive:

__ Constipation/gas/bloating

__ Irritable bowel syndrome

__ Other _____

Nervous System:

__ Herpes/shingles _____

__ Numbness/tingling _____

__ Fatigue _____

__ Sleep disorders _____

__ Other _____

Pregnancy (Stage _____)

__ Vaginal fluid/bloody discharge

__ Visual disturbances

__ Severe nausea/vomiting

__ Severe headaches

__ Upper right quadrant pain

__ Edema above mid-shin area

Infectious Disease:

__ Disease name(s): _____

_____

Skin:

__ Allergies

__ Rashes

__ Athletes foot

__ Open sores

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 that I am aware of and will update that massage practitioner of any changes in my health status.

Signature: _____ Date: _____

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Acknowledgement of Privacy Practices

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this consent.

Should the need arise, I authorize Pacific Chiropractic Clinic to share with the following people (spouse, family member, friend) information about my medical condition, treatment, payment and appointments:

_____ _____

Name Relationship Name Relationship

Can confidential messages (appointment reminders) be left on your telephone voicemail? __ Yes __ No

You have the right to request that we restrict the use and disclosure of your health information. We are not required to agree to this request, but if we do we are bound by our agreement.

By signing this form, you understand that your health information can and will be used to provide and coordinate treatment among other health care providers who may be involved in your treatment directly and indirectly. It will be used to obtain payment from insurance companies/third-party payers for health care services.

You have the right to revoke this consent, in writing, understanding that we cannot take back disclosures that have already been made of your prior consent.

_____

Print Name

_____ _____

Patient or legally authorized individual signature Date

Welcome to Pacific Chiropractic Clinic!

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Please read and acknowledge the following financial agreements regarding Massage Therapy.

For ALL massage therapy patients:

- Please call at least 24 hours prior to your massage appointment if you need to cancel, otherwise you will be responsible for a $30 cancellation fee. This fee must be paid before your next massage appointment.

For therapeutic/injury massage:

- Please make sure you schedule with a massage therapist that is contracted and in-network in order to receive the highest benefit from your insurance company.
- Your patient portion/co-payment will be collected on the same day you receive massage.
- Your insurance may require authorization for massage therapy. They generally authorize 4 visits initially. Additional visits require further authorization and we cannot guarantee that your insurance company will pay for your visits, no matter what documentation we provide.
- If they do not authorize it, you will be responsible to pay for that visit.

For general wellness massage:

- You understand this is a massage for your general well-being.
- Payment is expected at the time of service.

_____ _____

Patient Date