Pacific Chiropractic Clinic

7503 196th St SW, Lynnwood, WA 98036

425-775-8000

Name: ____ Date: _________________

Phone: ________________________ Emergency Contact/Phone: ______________________

Birthdate: ___________________ Email: ____

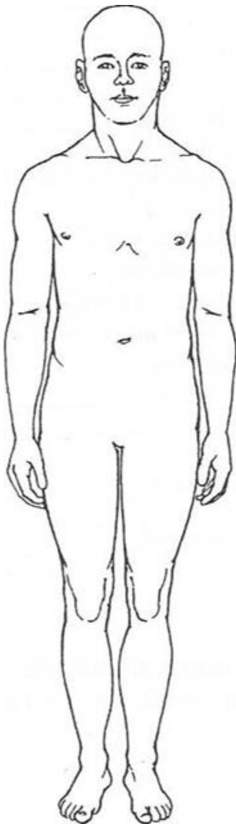
Address: ____

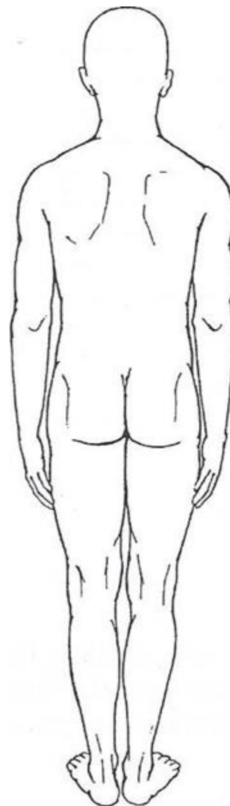
City: ________________________________ State: _________ Zipcode: _______________

- 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

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

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

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

Welcome to Pacific Chiropractic Clinic!

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Informed Consent:

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. Because a massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part if I fail to do so.

This is a therapeutic massage session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. I understand the massage therapist reserves the right to refuse services to me for any reason that they deem necessary.

Draping with sheets/blankets will be used for your privacy and comfort at every massage session. Genitalia and women's breasts will not be exposed or touched at any time.

Please read and acknowledge the following financial policy 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 $50 cancellation fee. This fee must be paid before your next massage appointment.

We do not bill any commercial insurance companies (regardless of the member's coverage) for massage therapy. Pacific Chiropractic Clinic will accept the following:

- Work accidents
- Car Collisions and Personal Injuries
- Self pay

For general wellness massage:

- You understand this is a massage for your general well-being.
- Payment is expected at the time of service.
- No receipt for insurance can be provided

I have read and I acknowledge the above treatment and financial policies.

____   ______________________

Patient   **Date**