WELCOME TO:

ALLIANCE CHIROPRACTIC & MASSAGE

610 E. Broad Street Souderton, PA 18964 215-723-7500 www.alliance-chiro.com

PLEASE FILL OUT COMPLETELY

Name_____Date_____

Referred by:_____

Address_____

_____

Phone [H](___)_____ [C](___)_____

Occupation_____

Date of Birth_____ Age_____

E-Mail_____

Have you ever received massage therapy? ☐ Yes ☐ No

If yes, where?_____When?_____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Are you currently under a physician's care? ☐ Yes ☐ No

If yes, Why?_____

SYMPTOMS

- ❑ **Headaches**
- ❑ **Neck Pain**
- ❑ **Arm Pain**
- ❑ **Shoulder Pain**
- ❑ **Numbness**
- ❑ **Tingling**
- ❑ **Pins & Needles**
- ❑ **Weakness**
- ❑ **Low Back Pain**
- ❑ **Mid Back Pain**
- ❑ **Leg Pain**
- ❑ **Knee Pain**
- ❑ **Hip Pain**
- ❑ **Arthritis**
- ❑ **Stress**
- ❑ **Fibromyalgia**
- ❑ **None**

List problem areas

_____

_____

When did it start?

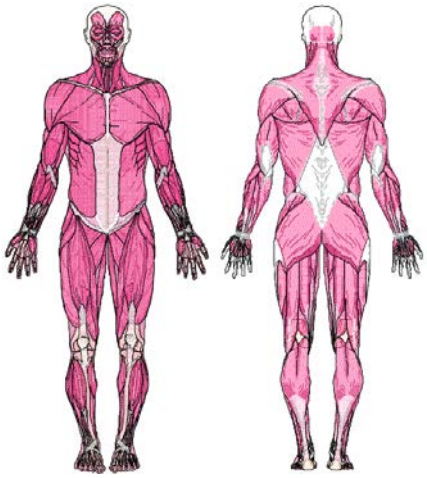
_____

How important is it to eliminate this pain?

0 1 2 3 4 5
(circle)

Have you ever been seen by a chiropractor? ☐Yes ☐ No
If yes, when?_____

SHADE AREAS OF DISCOMFORT



*** PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE ***

- ❑ Allergies
- ❑ Sinusitis
- ❑ Arthritis
- ❑ Bursitis
- ❑ Diabetes
- ❑ Varicose Veins
- ❑ Blood Clots
- ❑ Heart Condition
- ❑ Severe Depression
- ❑ Cancer
- ❑ Shortness of breath
- ❑ Fatigue
- ❑ Dizziness
- ❑ Loss of balance
- ❑ Fainting spells
- ❑ Headaches
- ❑ TMJ dysfunction
- ❑ Herniated disc
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Insomnia
- ❑ Chest Pain
- ❑ Numbness of hands
- ❑ Numbness of feet
- ❑ Edema
- ❑ Skin disorders
- ❑ Hepatitis
- ❑ Constipation
- ❑ HIV
- ❑ Abdominal hernia
- ❑ Stomach disorders
- ❑ Sciatica
- ❑ _____

List ALL Vitamins and Medications you are currently taking: _____

_____

You are responsible to make the massage therapist aware of any existing physical health conditions or changes you may have. I understand and agree to the following:

1. Massage therapy is for the purpose of stress reduction, relief of muscular tension or spasm, & improving circulation.
2. Massage therapists neither diagnoses illness, disease nor other medical, physical, or mental disorder, nor do they perform spinal manipulations.
3. I am responsible for consulting a qualified physician for any physical ailments I may have.
4. Services rendered for auto or workers' comp injuries are billed directly to insurance companies and I authorize payment of medical benefits to this office. Health insurance does NOT cover massage and I am directly responsible for payment.
5. I agree to pay for all scheduled appointments unless I notify the office at least 24 hours in advance.
6. The information given is correct to the best of my knowledge. I acknowledge that I will not hold the Doctor or any member of the staff responsible for any errors or omissions I may have made in the completion of this form.

Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF CLIENT MASSAGE INFORMATION

Print Name_____ **Date of Birth**_____

I authorize any medical, osteopathic, chiropractic physician, medical practitioner, healthcare provider, rehabilitation facility, hospital, clinic or any other healthcare facility to disclose information from medical and healthcare records.

I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, diagnostic tests, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans, and other information with ALLIANCE CHIROPRACTIC doctors, associates, and staff. I understand Alliance Chiropractic may disclose medical or other information obtained by this authorization to physicians, other medical or healthcare providers or other professions for their professional opinion.

I understand that I may refuse to authorize disclosure of all or some of the requested information. This authorization may be revoked at any time in writing, dated, and signed. This specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act. I understand this authorization was developed pursuant to the Heath Insurance Portability and Accountability Act of 1996. (HIPAA)

_____ _____

SIGNATURE OF CLIENT, GUARDIAN OR PERSONAL REPRESENTATIVE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received and read a copy of this office's Privacy Practices and sign this document as a free and voluntary act.

Alliance Chiropractic strives to keep your Health Information Private. We understand your medical information is personal and we are committed to protecting it, however, in our daily procedures, the following may possibly compromise your privacy:

* Phone calls; patients' charts and cards in use; x-rays in use, discussions amongst Doctors, Patients, Staff or Authorized visitors; appointment books; mailings; receipt books; computers; bulletin boards.

As a patient in our practice, we may need to communicate with you, please list any forms of communication that are not acceptable_____

It is understood that person(s) having access to the same devices may intercept the communication

I have the right to revoke this authorization at any time in writing. I have the right to refuse to sign this authorization.

_____ _____

SIGNATURE OF CLIENT, GUARDIAN OR PERSONAL REPRESENTATIVE **DATE**

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because_____

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ALLIANCE CHIROPRACTIC'S MASSAGE THERAPY POLICY

We would like to take this opportunity to thank you for choosing Alliance Chiropractic for your massage needs. The guidelines below are to be followed by the massage therapist and client to ensure comfort and privacy. Thank you, in advance, for your co-operation.

- We want to make sure you are a candidate for massage therapy. Please take time to fill out an intake form of your past and present medical history. This will help determine your needs.
- Our therapists are on a tight schedule and we want to insure all clients receive the full service they scheduled. Arrive 5-10 minutes prior to your scheduled appointment.
- If you need to change or cancel your appointment, please do so with as much notice as possible. If you do not cancel within **24** hours of your appointment, you will be charged the fee for a one hour massage ($60.00).
- Your private areas will be draped at all times and will not be massaged.
- Inappropriate comments or behavior of any sexual nature is not tolerated and your massage will be terminated immediately and you will be barred from this office.
- Whether or not to treat is solely at the discretion of the massage therapist.
- If you have any questions or comments please feel free to express them to the therapist.
- Payment is expected at time of service by cash, check or credit card.

I read and agree to the massage therapy policy.

_____ _____

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE