Intake Form

Name________________________________ Date of Birth __________________ Today's Date ______________

Address________________________ City_________________________ State________ Zip_______________

Home Phone (_____)___________________ Cell Phone (_____)__________________ OK to Text? Yes No

Office Phone (_____)___________________ Occupation __________________________________

Emergency Contact _____________________ Relationship_____________ Telephone (_____)_____________

How often do you normally receive massage? ____

Who referred you today? ____

Do you have trouble laying on your back, front, or side? Yes No

Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin? Yes No

If yes, please explain ____

Do you have any scent intolerances? Yes No If yes, Explain: ____

Do you wear: ( ) Contact lenses ( ) Dentures ( ) Hearing aid(s)?

Do you have any limitations due to surgery? If so, please list ____

Check all that apply:

- ○ Allergies
- ○ Arthritis
- ○ Artificial joint
- ○ Atherosclerosis
- ○ Blood clots
- ○ Blood pressure (high/low)
- ○ Bruise easily
- ○ Cancer
- ○ Circulatory disorder
- ○ Current fever
- ○ Contagious skin condition
- ○ Decreased sensation
- ○ Diabetes
- ○ Headaches
- ○ Heart condition
- ○ Infection
- ○ Inflammation
- ○ Joint disorder
- ○ Kidney disorder
- ○ Lymph node removal
- ○ Medication affecting blood clotting
- ○ Menstrual cramps
- ○ Non-contagious skin condition
- ○ Open sores or wounds
- ○ Osteoporosis
- ○ Pins, rods, or plates
- ○ Pregnancy
- ○ Previous MVA/trauma
- ○ Recent accident or injury
- ○ Rheumatoid arthritis
- ○ Ruptured/bulging disk
- ○ Seizures/epilepsy
- ○ Stroke
- ○ Surgery
- ○ Swollen glands
- ○ Varicose veins/thrombophlebitis

Please briefly explain all checked areas (if this massage is for a recent accident, please specify date of occurrence):__________

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Kneaded Balance massage

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? ____
____
____

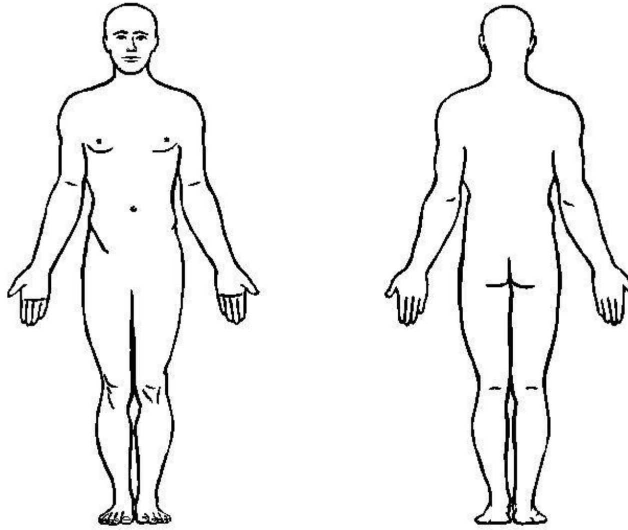
Are you under any medical supervision?____

Primary physician ______________________ Telephone (___)______________

Are you currently taking any medication? If so, please list ______________________________
____

Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort? Yes No

If yes, please indicate below:



Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain ____
____

I understand that the massage therapy given to me today and in future treatments is for the purpose of general health and wellness, relaxation, improved circulation, pain management, and other effects supported by experience and research. Massage therapy will be performed within the scope of practice of massage practitioners in this state.

I understand that massage therapy is not a substitute for a medical examination, and that it is recommended that I first seek medical attention for diagnosis and treatment of any suspected medical problem. I agree that it is my responsibility to keep my massage practitioner informed of any changes in my health, and of any medication changes that may occur.

I understand that Kneaded Balance Massage has posted it's policies online at: kneadedbalancemassage.com, and it is my responsibility to read them. Any questions regarding these policies may be directed to the therapist.

I have received a copy of the Privacy Policy. I have read the notice and understand this authorization form.

I understand I am responsible for each massage at its completion. Acceptable payments: Cash, Check, Credit/Debit, and/or Insurance.

Signature ______________________________ Date ____________________

Privacy Policy

Kneaded Balance Massage is happy to provide you great service. A part of that service is providing and protecting your privacy. This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In order to provide you proper treatment, I may gather information from you, other health care providers and third party payers. This information is only used for treatment, payment and other health care operations. The following describes the ways I may use and/or disclose your PHI:

* I may provide PHI about you to other pertinent health care providers, other practice personnel, or third parties involved in the provision, management or coordination of your treatment.
* I may disclose your PHI to any third party you designate in writing.
* I may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* I may disclose your PHI if I believe it is necessary in order to prevent a serious threat to your health and safety and/or to that of the public.
* I may disclose your PHI to a government agency if I believe you have been a victim of abuse, neglect or domestic violence. I will make this disclosure if: it is necessary to prevent serious harm to you and/or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or if/when required by law.
* I may disclose your PHI to a health oversight agency for activities authorized by law.
* I may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
* I may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
* I may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
* Your PHI may be disclosed for military/veterans affairs, for national security and intelligence activities, or for correctional activities when required.
*I may use or disclose your PHI when required by law.
* I may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, information about alternative therapies, or other related information that may be of interest to you. If there is no answer, a message will be left on your answering machine/voicemail. If indicated that you can receive text messages, you may be notified by text. Text message fees may apply depending on your carrier services.

Please note your rights regarding this information:
1. You are entitled to inspect and receive copies of your records.
2. You are entitled to make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. I will accommodate any reasonable request, however I retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. I am not required to honor these requests. If I agree with your restrictions, the restriction is binding on us.
7. You may complain to me or the Secretary for Health and Human Services if you feel that I have violated your privacy rights. There will be no retaliation for filing a complaint.

Written comments should be addressed to me or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.