NEW PATIENT HEALTH HISTORY FORM

PATIENT INFORMATION

Name (Last, First, Middle): _____

Date of Birth: _____Age: _____ Male _____Female _____Other_____

Marital Status __Single __Married __Widow __Divorce __Other

Address:_____City:_____State:_____ Zip:_____

Home Phone: _____ Cell/Work Phone:_____

Occupation:_____

Employer/School Name & Address:_____

Emergency Contact Person:_____ Phone:_____

Primary care physician: Name_____ Address_____Phone_____Email_____

OFFICE PROTOCAL AND PROCEDURAL EXPLANATION

1. Do you have pain, headaches or spasms that may interfere with your daily activity?
2. Currently are you receiving treatment with No/Fault or W/C?
3. The insurance may send a question form regarding N/F or W/C; they are just confirming.
4. Patients are afforded **3 visits for Massage therapy 3 visits for Acupuncture per week.**
5. Prior to receiving any services, you must be **diagnosed by a medical doctor.**
6. Medical massage is billed as Massage Therapy but the EOB reflects **Medical Services.**
7. Acupuncture is billed as Acupuncture but the EOB reflects **Medical Services.**
8. Trigger Point Therapy is billed as TP but is interpreted on the EOB **Surgery.**
9. Often, when there is **ultrasound** it may be considered as **Radiology.**
10. **ALL INSURANCE CHECKS MUST BE BROUGHT IN WITHIN 30 DAYS OF RECEIPT with signed back of check and EOB.**
11. **Tips** are allowed but not mandatory for massage therapists.
12. **Cell phone** _____ **Email** _____so we may contact and confirm your appointments.
13. **24 hour cancellation policy:** cancellation within 24 hours **without an emergency** will result in a **$100 fee we will be calling to follow up on your cancellation to make sure we are covid compliant**.
14. **PATIENTS MUST GET FOLLOW-**UP VISITS WITH MEDICAL DOCTOR AND RECEIVE PRESCRIPTION FOR MASSAGE OR ACUPUNCTURE. If you decide not to see the doctor at our facility.

MEDICAL MASSAGE INFORMATION

Have you had a massage before? __yes __no

What pressure do you prefer? __Light__Medium __Deep

Do you have any allergies or sensitivities? __yes __no

_____

_____

Are there any areas (feet, face, abdomen, etc:) you do not want massaged? __yes __no

Please explain:_____M_____

What are your goals for this treatment session? _____

By signing below you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature: _____ Date: _____

PATIENT MEDICAL INFORMATION (CONFIDENTIAL)

CHIEF COMPLAINT(S)/INJURY DESCRIPTION

• Chief Complaint(s): _____

• Onset date: when did this symptom(s) begin?_____ • Have you had this symptom(s) before? ☐ No ☐ Yes: when?_____

• Is this an Injury? ☐ No ☐ Yes: Date of Accident/Injury: ____/____/____ Time: ____:____(AM/PM) Location: _____

Nature of the Injury: ☐ Auto Collision ☐ On-the-Job Injury ☐ Other • Description: _____

If auto accident, you were a ☐ Driver/☐ Passenger/☐ Pedestrian and struck from ☐ Behind/☐ Rt. Side/☐ Lt. Side/☐ Front/☐ Auto was parked

If an Attorney is involved, Attorney's Name: _____ Phone: (_____) _____

• Are you currently working? ☐ N/A ☐ No ☐ Yes: If no, last date worked: _____ If yes, any restrictions? _____

• Have you had Surgery for this Injury? ☐ No ☐ Yes: Type of surgery: _____ Date of surgery: _____

• Medical Care/Treatment related to current condition/injury (check all that apply and write date of the care/treatment)

☐ X-ray _____ ☐ Primary Doctor _____ ☐ Orthopedic Dr._____ ☐ Neurologist _____

☐ MRI _____ ☐ Chiropractor _____ ☐ Physical Therapy _____ ☐ Other: _____

• Have you received any Physical Therapy Service this year? ☐ None ☐ 1-5visits ☐ 6-10visits ☐ 11-15visits ☐ 16-20visits ☐ > 21 visits

PAIN HISTORY/DESCRIPTION

• How would you rate the pain on scale of 0-10? (mark O for current pain, × when it's worse)

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate		Severe		Very Severe		Worst

• Pain Description (mark all that apply)

☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Burning ☐ Numb/Tingling ☐ Spasm/Stiff ☐ Radiating

• What makes it better? Activity: _____ Time of day: _____

• What makes it worse? Activity: _____ Time of day: _____

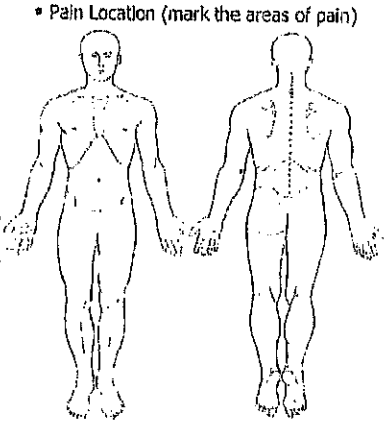
• Check those activities below during which you experience difficulty:

☐ Pulling ☐ Pushing ☐ Lifting ☐ Bending forward/backward ☐ Squatting ☐ Sitting for long time

☐ Sit to Stand ☐ Standing for long time ☐ Walking ☐ Stair Climbing ☐ Running ☐ Sports

☐ Dressing ☐ Toileting ☐ Bathing ☐ Getting in/out of car ☐ Sexual Activity ☐ Grocery Shopping

• Pain Location (mark the areas of pain)



MEDICAL CONDITIONS/MEDICATIONS

• Do you have, or have you had any of the following? (mark all that apply)

☐ AIDS/HIV Positive
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma/Bronchitis
☐ Blood Clot
☐ Cancer:_____
☐ Cataracts/Glaucoma
☐ Coronary Heart Disease/Angina
☐ Diabetes
☐ Emphysema/COPD
☐ Epilepsy
☐ Gout
☐ Heart Attack
☐ Hepatitis
☐ Hernia
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease:_____
☐ Liver Disease: _____
☐ Migraine/Headaches
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinsonism
☐ Pneumonia
☐ Prostate Problem
☐ Sleeping Problems
☐ Stroke/TIA
☐ Thyroid Problems
☐ Ulcers:_____
☐ Incontinence(Urinary/Fecal)
☐ Complicated Pregnancy/Delivery
☐ Endometriosis
☐ Miscarriage
☐ Pelvic Inflammatory Disease
☐ Vaginal Infections
☐ Pins/Metal Implants:_____
☐ Joint Replacement: _____
☐ Neck/Back Surgery
☐ Shoulder/Arm/Hand Surgery
☐ Knee/Ankle/Foot Surgery
☐ Heart Surgery: _____
☐ Other Organ Surgery:_____

• List Medications/Drugs/Supplements/Herbs you are currently taking: _____

_____

MASSAGE CONSENT FORM

I have been advised of all the policies and procedures pertaining to massage and I understand these policies. The massage procedures, information about massage in general, benefits and contraindications of massage, and possible alternative therapies have been explained to me.

I understand that the massage I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain, and to increase circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods can be adjusted to my comfort level. I understand that massage therapists do not diagnose illness or disease, nor do they perform spinal manipulations or prescribe any medical treatments, and nothing said or done during the session should be constructed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis, and I should see a health care provider for those services. I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist and Holistic Health Clinic from any liability if I fail to do so.

_____ _____

Signature of Patient Date

Consent to Treat a Minor

I _____ parent/guardian of _____ have read and understood the statements regarding massage therapy. By my signature I authorize a Holistic Health Clinic massage therapist to provide massage treatments and body work to my child or dependent.

_____ _____

Signature of Parent/Guardian Date

AUTHORIZATION & SIGNATURE

__INSURANCE ASSIGNMAENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance, I authorize the use of my signature on all insurance submissions. _____ may use my health care information and may disclose such information to the above names company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will and when my current treatment plan is completed for one year from the date signed below.

Client Signature: _____ Date: _____

ACUPUNCTURE CONSENT FORM

NAME_____ DOB:_____

I hereby request and consent the performance of acupuncture treatment and other Oriental Medicine procedures by the below named licensed acupuncturist and/or other licensed acupuncturists to now or in the future treat me while employed by working or associated with or serving as a back-up for the treating acupuncturist named below including those working at the office or any other office or clinic.

I understand that: Acupuncture Therapy is not a substitute for medical examination and diagnosis. It is recommended that I see a medical doctor for any physical ailment for which I may seek acupuncture treatment. I fully understand that: The acupuncture therapy is a safe method of treatment. I have been informed that acupuncture therapy may involve the insertion of several sterile and disposable needles into the skin and realize that some bruising, soreness and superficial bleeding are on occasional occurrence near the needle sites that last for a few days.

Cupping bodywork therapy is an adaptation of an ancient technique; the purpose of it's technique to promote health and healing by: loosening soft tissue and connective tissue scarring and adhesion moving stagnation and increasing lymphatic flow and circulation. This therapy utilizes silicone or plastic cups and vacuum pistol to create suction on the body surface. These cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup or may be parked for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into the soft tissue, attachments and organs. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them.

Potential Reactions to Cupping are temporary and may include:

- Discoloration due to toxins and old blood being brought to the surface
- Post tenderness: usually less than experienced from deep tissue work
- Redness and Itching: increased vaso-dilation and/or inflammation brought to the surface
- Decreased Blood Pressure; due to vaso dilation and/or nervous system sedation

I understand that: The clinical and administrative staff can review my medical records and all reports, but all my records will not be released without my written consent.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing agree in the above-named procedures.

I intend this consent for to cover the entire course of treatment for my present condition and any future condition(s) for which I may seek treatment.

Patient's Name (or guarantor)	Signature	Date
Name of Treating Acupuncturist	Signature	Date

MEDICAL TRIGGER POINT THERAPY CONSENT FORM

NAME: _____ DOB: _____

THE TREATMENT

Trigger point injections (TPI) is used to treat extremely painful and tender areas of muscle. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight band in muscle that forms when muscle fails to relax. The knot often can be felt under the skin and may twitch involuntary when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain-pain felt in another part of the body or in teeth. Scar tissue and loss or range of motion and weakness may form over time. A small needle is inserted into the trigger point and local anesthetic (e.g. lidocaine, procaine), anti-inflammatory or steroid is injected. Trigger point injections have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold and individualized medication program.

RISK AND COMPLICATIONS

Before undergoing the procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks that are not included on this list. It has been explained to me that there are certain inherent and potential to; 1. You may develop infection; 2. You may experience bleeding; 3. You may develop irritation at the injection site; 4. There may be skin changes; 5. You may develop bruising, redness or swelling; 6. The lung (or the pleura, which is the surrounding membrane) may be punctured if the procedure is performed in a muscle near the ribcage, and 7. The procedure may fail to reduce the pain symptoms. Some of these risks, if they occur, may necessitate additional surgery, hospitalization, and/or outpatient therapy to permit adequate treatment.

RESULTS

Trigger point injections is used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments, although there is some debate over its effectiveness. The doctors cannot guarantee you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with trigger point injections for myofascial pain, TMG dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Patient's Name (or guarantor)	Signature	Date
Doctor's Name	Signature	Date