Brain and Body Therapy
CREATING CHANGE

New Patient Information Packet – Adult

Date: _____

Name: _____ Sex: □ Male □ Female
First M.I Last
Pronouns: _____

Nickname/Preferred Name: _____ DOB: _____ Age: _____
D / M / Y

Address: _____
Street City State Zip

Email: _____ Phone:_____ □ Work □ Cell □ Home

Appointment Reminders: □ Text □ Email May we leave messages at this number? □ Yes □ No

Emergency Contact:_____ Pronouns: _____
First M.I Last

Relation to Patient:_____ Phone:_____

Primary Care Provider/Doctor: _____
First M.I Last

Office: _____ Phone:_____

Do we have permission to contact your PCP if necessary? □ Yes □ No

How did you hear about us?

□ Social Media □ Google Search □ Referral/Word of Mouth □ Flyer □ Other

If you heard about us through word of mouth, who can we thank? _____

Would you like subscribe to our e-mail list? We'll send you any upcoming deals and any service changes. We won't spam you, promise! □ Yes □ No

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Medical History

In the last 2 years have you experienced any events which needed hospitalization? □ Yes □ No (if yes, please explain)

_____

_____

_____

Please indicate any of the following that apply to you:

□ Concussion □ Dizziness □ Anxiety □ Depression □ Whiplash

□ Sensory Processing □ Joint Replacement □ Diabetes □ High/Low Blood Pressure

□ Numbness □ Fibromyalgia □ Neuropathy □ Kidney Dysfunction □ Cancer

□ Arthritis □ Sprains or Strains □ Stroke □ Blood Clots □ Heart Attack

□ Headaches/migraines □ Varicose Veins □ Repetitive Stress Injury □ Fatigue

Please List Other Known Diagnoses Date of Diagnosis

_____

_____

_____

_____

Current Medications Treating for.. Dosage AM/PM

_____

_____

_____

Are there other areas in your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?

_____

_____

_____

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Therapy Focus

Do you exercise? □ Yes □ No If yes, how many times per week? _____ For how long? _____

Have you ever experienced massage/bodywork before: □ Yes □ No

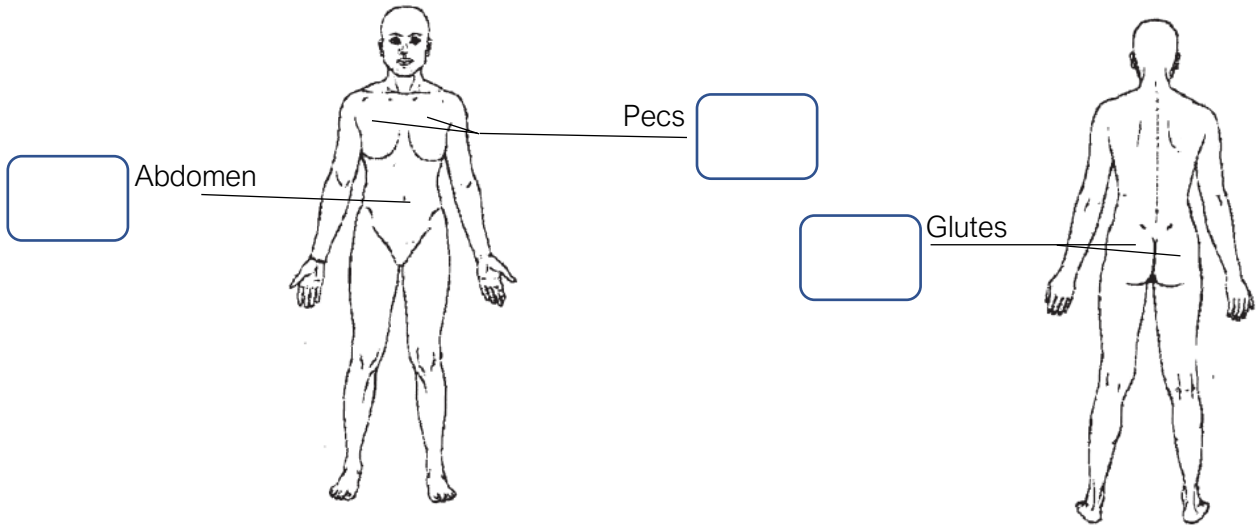
How often do you receive massage/bodywork? _____

Do you have any known allergens to oils/lotions? □ Yes □ No If yes, please explain: _____

Please initial next the following statement:

_____ I agree to have the massage therapist work on my head/neck, back, arms, hands, legs, and feet.

In addition, please initial in the box next to each area you allow permission for the massage therapist to work on:



Please specify areas which you do **not** want worked on: _____

What are your primary goals for therapy?

_____

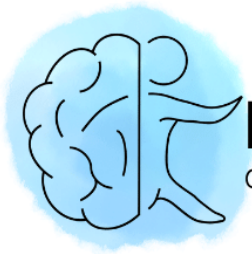
_____

_____

Are there specific target areas you would like the massage therapist to focus on?

_____

_____



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HIPAA Privacy Authorization Form

Effect Date (today's date): _____

Authorization for Use or Discussion of Protected Health Information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization. I authorize Brain and Body Therapy (healthcare provider) to use and disclose the protected health information described below to any medical entities as needed.
2. Effective Period. This authorization covers all past, present, and future period of health care.
3. Extent of Authorization. I authorize the release of my complete health record.
4. Use. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation or other purposes as I may direct.
5. Termination. This authorization shall be in force and effect until 2 years from effect date at which time this authorization form expires.
6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already active in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim
7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. Disclosure. I understand that Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name: _____

Signature (or Personal Representative): _____

Date: _____

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Consent to Treat

I hereby certify that I am pregnant and am medically fit to receive massage services. I certify that:

- I have provided Brain and Body Therapy with my full medical history. I will inform my therapist of any medical changes.
- I will inform the therapist so that the pressure and/or strokes me be adjusted for my comfort.
- I acknowledge that massage and bodywork by Brain and Body Therapy should not be construed as a subsidize for medical examination, diagnosis, or treatment and that I should see my primary care provider, a physician, chiropractor, or other qualified medical specialist of a mental or physical ailment that I am aware of.
- I acknowledge that Brain and Body Therapy may bring in equipment into my household as part of the treatment session which includes but not limited to: massage table, massage chair, linens, bolsters, Bal-A-Vis-X (BAVX) equipment. I am responsible for any damage done to equipment by individuals outside of the scheduled client (pets, other children, etc.).
- In the event I need medical assistance (Heimlich maneuver, CPR, etc.) or require medical equipment (inhaler, EpiPen, etc.) I will provide item whereabouts and demonstration proper item usage. I give permission to the treating therapist to utilize his/her professional judgement to intervene in event of medical necessity.
- I will provide payment at time of service.
- I hereby waive and release the massage therapist and associated business from any and all rights and claims for damages that may occur during or after the treatment session.

I hereby certify that the above statements are true and correct.

I _____ (print name) request and consent to be treated.

Signature: _____ Date: _____