



**Personal Health Information**

**Personal Data**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthday: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Permission to consult with primary? Please initial if yes.  Yes \_\_\_\_\_  No

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Massage History**

Have you ever received a professional massage?  Yes  No

If yes, Frequency \_\_\_\_\_ Date of last massage: \_\_\_\_\_

What results do you want from your massage sessions? \_\_\_\_\_  
\_\_\_\_\_

Prioritize the areas of your body that you would prefer to be massaged? \_\_\_\_\_  
\_\_\_\_\_

Please check the areas of your body that you give permission to receive massage:

Back  Legs  Buttocks  Arms  Abdomen  Chest  Neck  Head  Face  Other

Are you currently seeing a medical practitioner? If yes explain:  Yes  No \_\_\_\_\_

List stress reduction and exercise activities. Include frequency: \_\_\_\_\_  
\_\_\_\_\_

List current medications, including aspirin etc.: \_\_\_\_\_  
\_\_\_\_\_

Previous History (Include year and treatment received)

Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Accidents: \_\_\_\_\_  
\_\_\_\_\_

# Health History

## Muscular-skeletal

- \_\_\_\_\_ Bone or Joint Disease \_\_\_\_\_
- \_\_\_\_\_ Tendonitis \_\_\_\_\_
- \_\_\_\_\_ Bursitis \_\_\_\_\_
- \_\_\_\_\_ Broken/ Fractured Bones \_\_\_\_\_
- \_\_\_\_\_ Arthritis \_\_\_\_\_
- \_\_\_\_\_ Sprains/ strains \_\_\_\_\_
- \_\_\_\_\_ Low back, hip, leg pain \_\_\_\_\_
- \_\_\_\_\_ Neck, shoulder, arm pain \_\_\_\_\_
- \_\_\_\_\_ Headaches/ Head injuries \_\_\_\_\_
- \_\_\_\_\_ Spasms/ cramps \_\_\_\_\_
- \_\_\_\_\_ Jaw Pain/ TMJ \_\_\_\_\_
- \_\_\_\_\_ Lupus \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## Circulatory

- \_\_\_\_\_ Heart condition \_\_\_\_\_
- \_\_\_\_\_ Varicose Veins \_\_\_\_\_
- \_\_\_\_\_ Blood Clots \_\_\_\_\_
- \_\_\_\_\_ High blood pressure \_\_\_\_\_
- \_\_\_\_\_ Low blood pressure \_\_\_\_\_
- \_\_\_\_\_ Lymph edema \_\_\_\_\_
- \_\_\_\_\_ Breathing difficulty \_\_\_\_\_
- \_\_\_\_\_ Sinus Problems \_\_\_\_\_
- \_\_\_\_\_ Allergies \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## Infectious disease

- \_\_\_\_\_ disease name \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Skin

- \_\_\_\_\_ Allergies \_\_\_\_\_
- \_\_\_\_\_ Rash \_\_\_\_\_
- \_\_\_\_\_ Athletes foot \_\_\_\_\_
- \_\_\_\_\_ Warts \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## Digestive

- \_\_\_\_\_ Constipation \_\_\_\_\_
- \_\_\_\_\_ Gas/ Bloating \_\_\_\_\_
- \_\_\_\_\_ Diverticulitis \_\_\_\_\_
- \_\_\_\_\_ Irritable Bowel syndrome \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## Nervous system

- \_\_\_\_\_ Herpes/ shingles \_\_\_\_\_
- \_\_\_\_\_ Numbness/ tingling \_\_\_\_\_
- \_\_\_\_\_ Chronic pain \_\_\_\_\_
- \_\_\_\_\_ Fatigue \_\_\_\_\_
- \_\_\_\_\_ Sleeping disorders \_\_\_\_\_
- \_\_\_\_\_ Others \_\_\_\_\_

## Reproductive

- \_\_\_\_\_ Pregnant? Stage \_\_\_\_\_
- \_\_\_\_\_ PMS \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## Other

- \_\_\_\_\_ Cancer/ Tumors \_\_\_\_\_
- \_\_\_\_\_ Diabetes \_\_\_\_\_
- \_\_\_\_\_ Eating disorders \_\_\_\_\_
- \_\_\_\_\_ Depression \_\_\_\_\_
- \_\_\_\_\_ Drug/ alcohol addiction \_\_\_\_\_
- \_\_\_\_\_ Nicotine/ caffeine addiction \_\_\_\_\_

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals; or perform spinal thrust manipulation. 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 the massage practitioner if any changes in my health status.

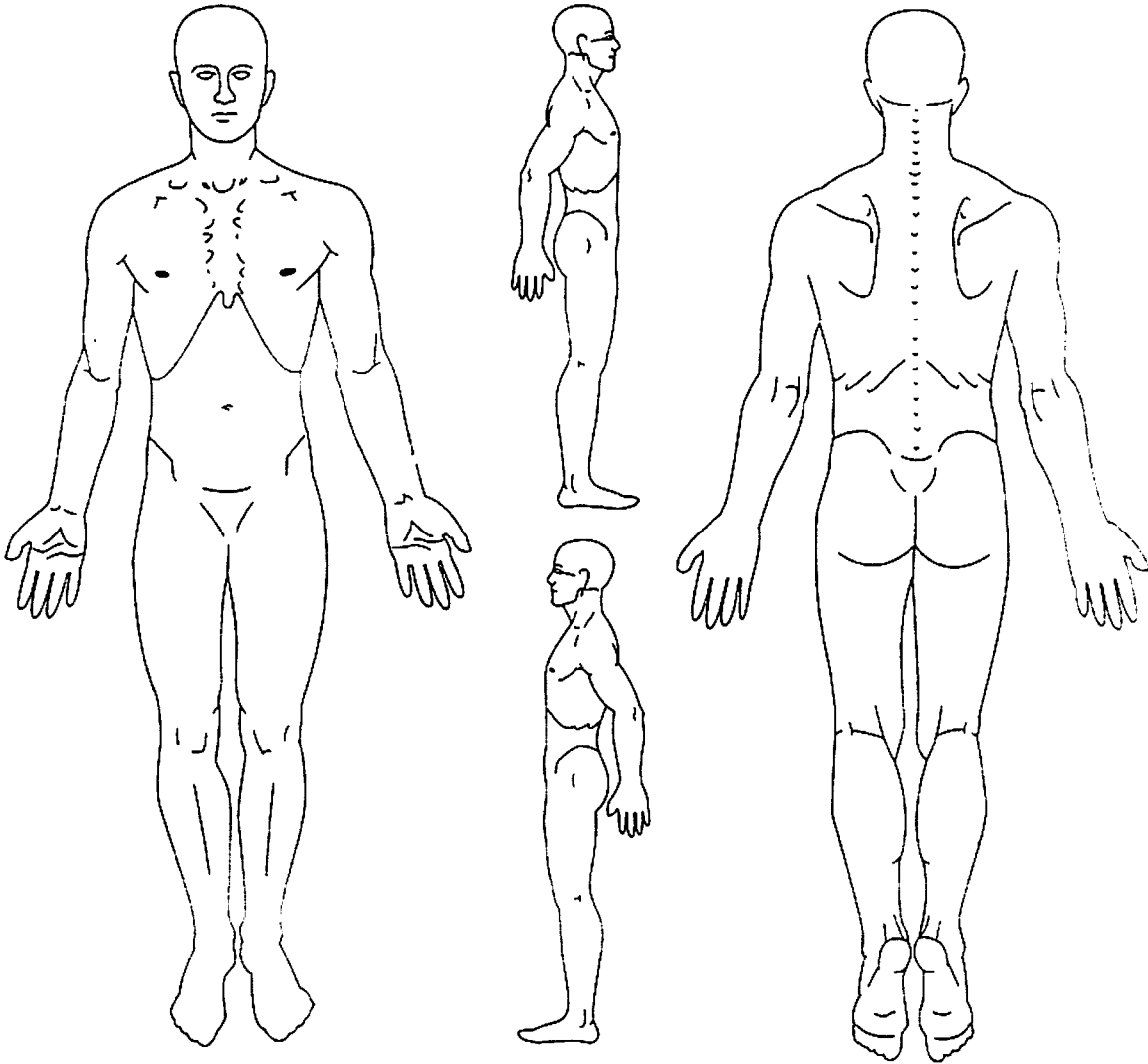
Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Identify current symptomatic areas in your body by drawing the symbols on the figures below.

- Key:
- Circle over areas of pain
  - ✕ "X" over areas of joint and muscle stiffness
  - ☆ Draw a star along the areas of numbness or tingling
  - ⚡ Mark scars, bruises, or open wounds



Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Date \_\_\_\_\_



# Massage Cancellation Policy

I understand that I must give a minimum of 24 hours notice to cancel a scheduled massage appointment. Failure to do so will result in a late cancel fee of \$25.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of the treatment, payment and health care operations.

**Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example we may need to share information with other health care providers or specialists involved in the continuation of your care.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a chiropractic plan for your chiropractic services.

**Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.

The right to request an amendment to your protected health information. We may deny your request in certain situations.

The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations... or based on your previous authorizations.

The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:	For more information about HIPAA or to file a complaint:
Privacy Officer	Dr. Shaun Reynolds
Office Name	Ultra Chiropractic
Address	1100 NE 47th Street, Suite 101
City, State, Zip	Seattle, WA 98105
Phone	(206)527-0123
	The U.S. Department of Health & Human Services
	Office of Civil Rights
	200 Independence Ave. S.W.
	Washington, D.C. 20201
	(877)696-6775 (toll-free)



# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Ultra Chiropractic  
1100 NE 47th Street Suite 101  
Seattle, WA 98105  
(206)527-0123

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my chiropractor's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my chiropractor has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_

**For Office Use Only:**

We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to following reason:

The patients refused to sign: \_\_\_\_\_

Communication barriers: \_\_\_\_\_

Emergency situation: \_\_\_\_\_

Other: \_\_\_\_\_