Sunbury Chiropractic
www.sunburychiropractic.com
123 State Route 3
Sunbury, OH 43074
Phone: 740.965.4301
Fax: 740.965.5182

Your local path to wellness™

Johnstown Chiropractic
www.johnstownchiropractic.com
620 West Coshocton Street
Johnstown, OH 43031
Phone: 740.967.2225
Fax: 740.967.8907

MASSAGE HEALTH INFORMATION

Patient Name: _____ Preferred Name: _____

Address: _____ Mobile Phone: _____

City: _____ State/Zip:_____ Home Phone: _____

SS#: _____ Preference for Phone Call: *Home* *Mobile*

Date of Birth: _____Gender_____ Marital Status: M S W D # children: _____

Email:_____ Occupation: _____

EMERGENCY CONTACTS

Name: _____ Relationship:_____ Phone number: _____

May we release Protected Health Information (PHI) to this individual? YES NO

Would you like to receive appointment reminders: **YES** **NO**

How did you hear about our office? _____

Have you had a professional Massage? _____

Massage Pressure Preference: LIGHT FIRM DEEP

Massage Missed Appointments: We have a high demand for massage therapy in our office. We kindly ask you to give us **24 hour cancellation notice** if you need to cancel or reschedule your appointment. If we are not notified 24 hours prior to your appointment, we reserve the right to charge a **$25 fee**. Any and all massage fees must be paid prior to making any additional massage appointments. If any fees are not satisfied, we reserve the right to not schedule your next massage appointment. Initial: _____

NOTICE OF PRIVACY PRACTICES: I have been offered the copy of Notice of Privacy Practices which outlines how my Protected Health Information may be used and disclosed, and how I can get access to the information. RECEIVED DECLINED
Initial: _____

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MASSAGE & MANUAL THERAPY POLICY & CONSENT TO TREAT

At Sunbury Chiropractic Center, we value massage therapy as a therapeutic compliment to chiropractic treatment. We strive to provide the best therapeutic health care possible.

We do not bill commercial health insurance for massage. However, our therapists are licensed by the Bureau of Workers' Compensation and the Veteran's Choice Program and massage is a billable service as long as an authorization is on file. If your insurance denies payment, the amount is your responsibility.

Massage/Manual Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment, and you should see a physician, chiropractor, or other qualified medical specialist if needed. During the course of the session, the massage therapist could recommend being seen by another health care provider. Massage therapists are not qualified to perform spinal adjustments, to diagnose a condition, or to prescribe anything to a patient, and nothing said in the course of the session is to be construed as such. You may experience pain or discomfort during the massage and should inform the massage therapist so that the pressure and/or techniques may be adjusted to your level of comfort. All patients will be appropriately draped with a sheet at all times during the session. Only the area/(s) of the body at are currently being worked will be exposed. The genital area is never exposed or massaged.

Because there are certain medical conditions in which massage/manual therapy is contraindicated, it is your responsibility to make it known if your health status changes or if you are suffering from latent pathological defects, illnesses, deformities, use of recreational drugs/alcohol or use of CBD oil which would otherwise not come to the attention of the massage therapist. I affirm that I have stated all known medical conditions and answered all questions honestly. There shall be no liability on the massage therapist's part, should I fail to do so. I am authorizing them to proceed with massage/manual therapy that they deem necessary. Furthermore, any risk or contraindication involved regarding massage treatment, will be explained to me upon my request or new conditions brought to the therapist's attention. I understand that the massage therapist may discuss my care with a chiropractic physician in this office as it falls within HIPAA guidelines.

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MINOR ONLY: Consent to Evaluate and Treat a Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive massage/manual therapy services with or without a parent or guardian present.

□ Mother/Legal Guardian:_____

□ Father/Legal Guardian:_____

I understand that information will be disclosed to all parents or guardians unless court documents are presented stating otherwise. All legal guardians need to submit court documents to our office to prove guardianship.

I have read SCC's Massage Therapy Policy and understand my responsibility for each session.

Patient Name: _____ D. O. B: _____

Patient/Guardian Signature: _____ Date: _____

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Health Information

What results do you want from your massage sessions?_____

_____

Are you taking any medications? YES NO If yes, please explain:_____

Any allergies? (oils, lotion, nuts, etc.) YES NO If yes, please list:_____

Are you pregnant? YES NO If yes, how many months: _____ Due Date:_____

Are you currently under medical supervision or receiving psychological interventions? YES NO

If yes, please explain:_____

List exercise activities(include frequency) _____

Rate your degree of flexibility: Excellent Good Fair Poor

Areas of broken skin, rash, wounds? YES NO If yes, where? _____

History of joint replacement surgery or spinal surgery? YES NO If yes, describe:_____

_____

Recent injuries, car accidents or medical procedures in the past 2 years? YES NO

If yes, please explain: _____

_____

Anxiety	**Y**	**N**	Difficulty Breathing	**Y**	**N**	Osteoporosis	**Y**	**N**
Areas of Swelling	**Y**	**N**	Difficulty Sleeping	**Y**	**N**	Osteoarthritis/Rheumatoid Arthritis	**Y**	**N**
Autoimmune Disorder	**Y**	**N**	Diabetes	**Y**	**N**	Phlebitis	**Y**	**N**
Back/Neck Problems	**Y**	**N**	Edema/Lymphedema	**Y**	**N**	Plantar Fasciitis	**Y**	**N**
Bleeding Disorder	**Y**	**N**	Fibromyalgia	**Y**	**N**	Scoliosis	**Y**	**N**
Blood Clots	**Y**	**N**	Headaches	**Y**	**N**	Seizures	**Y**	**N**
Bruise Easily	**Y**	**N**	Heart Condition	**Y**	**N**	Stroke	**Y**	**N**
Bursitis	**Y**	**N**	Hypertension	**Y**	**N**	Tendinitis	**Y**	**N**
Cancer	**Y**	**N**	Kidney Disease	**Y**	**N**	TMJ Disorder	**Y**	**N**
Chronic Pain	**Y**	**N**	Multiple Sclerosis	**Y**	**N**	Varicose Veins	**Y**	**N**
Contagious Condition	**Y**	**N**	Neurological Condition	**Y**	**N**	Vertigo/Dizziness	**Y**	**N**
Decreased Sensations	**Y**	**N**	Neuropathy	**Y**	**N**	Vision: Do you wear contacts	**Y**	**N**
Depression	**Y**	**N**	Numbness/Tingling	**Y**	**N**		**Y**	**N**

Any other conditions or areas of complaints? _____

_____

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PERSONAL STATUS REPORT

Name: _____ **Date:** _____

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

O – Circle areas of pain
X – "X" over areas of JOINT AND MUSCLE STIFFNESS
{ } – Draw a squiggly line along the areas of NUMBNESS OR TINGLING
ttt – Mark SCARS, BRUSISES or OPEN WOUNDS