Confidential Patient Health Record

Today's Date : ___/____/_______

How did you hear about us? ☐ Family ______________ ☐ Friend ________________ ☐ Co-Worker _______________
☐ Close to home/work ☐ Dr. ____________ ☐ Yellow pages ☐ Drove by ☐ Insurance Plan ☐ Internet/Website
☐ Health Fair ☐ Groupon ☐ Other: _________________

Personal Information

Last: ___________________________ First: ____________________________ Middle: _____________________________
Birth Date: ____ /____/______ Age: _____ Sex: ☐ Male ☐ Female
Home Phone: (_______) _______-_________ Cell Phone: (_______) _______-_________
Email Address: ______________________________
Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ Email
Address: ____Apt # ______
City: __________________ State: ______ Zip: _________ Country: __________________ County: _____________

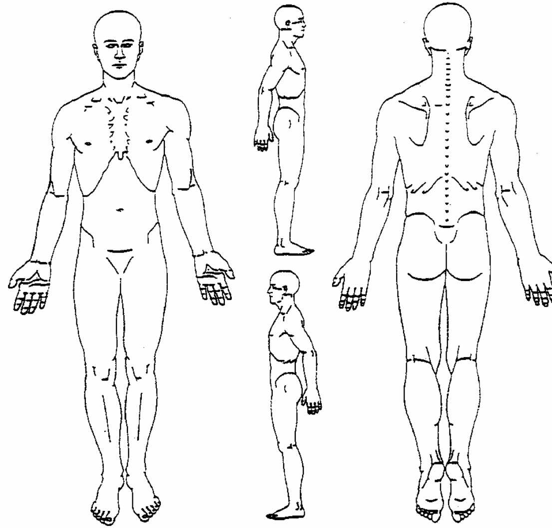
Emergency Contact

Last: ___________________________ First: ____________________________ Middle: _____________________________
Address: ____Apt # ______
City: __________________ State: ______ Zip: _________ Country: __________________ County: _____________
Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other: ______________________
Email Address: ______________________________
Home Phone: (_______) _______-_________ Cell Phone: (_______) _______-_________

Subjective:

Where do you notice your pain/discomfort? ____

(Please draw in below where you are experiencing pain/discomfort)



When did you first notice your pain/discomfort? ____

Was the onset of pain gradual or due to trauma? ____

How would you rate the severity of your pain on a Scale 1-10 (10 = worst pain)? ____________________

Have you ever had pain/discomfort like this before/if so please describe? ________________________

Describe your motion and/or position when you initially got injured? ___________________________

How did you get injured? ____

How would you describe the pain? ____

Which position/motion aggravates it? ____

What makes your pain feel worse? ____

Which type of massage are you interested in? ☐ Swedish (standard) ☐ Deep Tissue (*additional fee*) ☐ Combination

Are you interested in a specific type of Massage (*Additional fees may apply*)? ☐Reflexology ☐Trigger point ☐Neuro-muscular

Is this your first Massage? ☐ Yes ☐ No

How often do you receive massages? ☐ 2X week ☐ 1X week ☐ 2X month ☐ 1X month ☐ 1X every few months

When was your last massage? ____

Are there any areas that you would like your licensed massage therapist to focus on specifically? ie. Neck? Low Back?

____

Are there any areas that you would **NOT** like your massage therapist to work on? ie. Face? Legs? Arms?

____

PAST HEALTH HISTORY

Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) ______________________
Type of Treatment: ____________________ Were you satisfied with the results of your treatment? ☐ Yes ☐ No
Explain: ____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, Supplements: List ANY/ALL non-prescription items you are CURRENTLY taking.

Medication	Dosage	For What Condition?	How long have you been taking this?

Allergies: Mark all that apply below.

☐ Bactrim
☐ Cipofloxacin
☐ Codeine
☐ Oxycodone
☐ Hydrocodone
☐ Sulfa drugs
☐ other: _______________

☐ adhesive tape
☐ animals
☐ bee sting
☐ feathers
☐ latex
☐ mold
☐ newsprint

☐ perfumes
☐ smoke
☐ soap
☐ pollen
☐ chocolate
☐ dairy
☐ eggs

☐ food coloring
☐ nuts
☐ peanuts
☐ shellfish
☐ soy
☐ wheat
☐ other: _______________

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

1. angioedema
2. anaphylaxis
3. GI disturbance
4. headache
5. joint pain
6. rash
7. shortness of breath
8. unspecified reaction

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

☐ ear tubes
☐ Lasik
☐ Cataract Surgery
☐ tonsils
☐ adenoids
☐ dental surgery
☐ wisdom teeth
☐ thyroid
☐ pacemaker
☐ cardiac catheterization

☐ coronary artery bypass
☐ cardiac valve replacement
☐ angioplasty
☐ gastric bypass
☐ appendectomy
☐ abdominal aortic aneurysm
☐ gallbladder
☐ hernia repair
☐ hemorrhoidectomy
☐ mastectomy

☐ hysterectomy
☐ D & C
☐ cesarean section
☐ transplant
☐ spinal fusion
☐ discectomy level
☐ laminectomy
☐ shoulder
☐ carpal tunnel
☐ ganglion cyst

☐ knee repair
☐ bunionectomy
☐ joint reconstruction
☐ joint replacement
☐ cosmetic - face lift
☐ cosmetic - nose
☐ cosmetic - tummy tuck
☐ breast reduction
☐ breast enlargement
☐ other:

MASSAGE INFORMATION & INFORMED CONSENT

General Benefits: Increases in circulation, waste removal, range of motion, flexibility, energy, heart rate, body temperature, immunity, body awareness, and relaxation; decreases in discomfort, fatigue, tension, and stress levels.

General Contraindications: Medical emergencies (shock, hemorrhage, seizure, poisoning, etc.), high fever (102 degrees F), highly-metastatic cancer, intoxication, pain medications, or extreme fatigue (mental or physical). Work with Limitations: Open wounds, burns, inflammation, fractures, contagious or irritable skin conditions, recent surgery, pregnancy, recent injury, prescription medication, physicians' restrictions, or any immune system illness.

**Any client under physicians' care must notify the therapist of condition and changes. Working without physician approval may be detrimental to the physical well-being of the client.

Confidentiality: All information/conversation exchanged during a treatment session or about a treatment session remains confidential for the safety and wellbeing of the client and therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.
I understand that all health care procedures carry some risk. Some possible risks associated with Chiropractic, Physical Therapy, Acupuncture, and Massage Therapy (especially hot stone massage) may include, but are not limited to: muscle/ligament injuries, nerve/neurological injuries, vascular injuries, and muscular soreness (similar to that of exercise or a good work out).

I voluntarily consent to the rendering of treatment at Arizona Chiropractic & Holistic Health Center, which may include the performance of Chiropractic, Physical Therapy, Acupuncture, Massage Therapy, and other related therapies. The Doctors (Douglas Morris, D.C.) nor the office (Arizona Chiropractic) nor the Licensed Massage Therapist working on me will NOT be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. These parties will also not be responsible if I failed to give them any important health information that may be affected by any care given. I understand that there may be certain medical risks associated with the treatment I am about to receive and if anything goes wrong I will NOT hold any staff member at Arizona Chiropractic & Holistic Health Center nor the business/business owner liable or responsible for any injuries or conditions that may inadvertently occur as a result of the treatment.

Please note: All Licensed Massage Therapists are Independent Contractors; therefore, by signing below, you agree and acknowledge that you will not hold AZ Chiropractic Inc. nor its employees liable for any incident, injury, or conduct that may be caused by or may have resulted from an interaction with an Independent Contractor of the Company (ie: Massage Therapist).

Right of Refusal: Therapist and client both reserve the right to end a treatment session at any time for any reason. The therapist will fill out a disclosure statement to inform the client why the treatment session is ending. A client does not need to give any reason for ending a treatment session.

Sexual innuendos, language, and/or behavior will not be tolerated. The session will end immediately and the client will be charged full price.

I have read the previous information regarding the risks of massage. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient [or Parent/Guardian] Signature: ____ Date: ___________