Stangl Chiropractic & Massage Therapy
503 E. Clairemont Avenue, Eau Claire, WI 54701
Phone: (715)832-2223
www.TogetherForYou.com

Massage Therapy Intake Form

Date:_____

Client Information			
Name:			
Address: City, State, Zip:			
Home Phone:		Cell Phone:	
Email Address:			
Date of Birth:		Marital Status:	Single Married Divorced Widowed
Spouse/Significant Other Name:		Children:	□ Yes □ No
Employer:		Occupation:	
Emergency Information Contact	Name:_____ Relationship:_____ Address:_____ Phone:_____		
How did you find out about our office? Who can we thank for referring you?			

Massage History	
Have you ever received a professional massage?	□ Yes □ No
Why did you come for our service? (Please check all that apply) □General Well Being □Relaxation □ Stress Relief □ Pain Relief □ Reduce Muscle Tension □Improve Range of Motion □Return to Normal Function □Other_____	
We are here to serve your massage therapy needs. If you have preferences in the type of massage you receive or experience discomfort during your massage, please indicate this to your therapist so they are able to provide you with the massage that is best suitable to you!	

Current Condition	
Are you currently experiencing pain symptoms?	□Yes □ No
Where is the pain/symptom(s) located?	
Describe the quality of pain. (What does it feel like?)	

Current Condition (Cont.)

Frequency of Pain:	Intermittent Occasional Frequent Constant
Intensity of Pain :	(No pain) 0--1--2--3--4--5--6--7--8--9--10 (Worst Pain Possible)
When did the pain start?	
What caused/provoked it?	

Does it interfere with: □ Work □ Sleep □Daily Routine □ Recreation □ Other_____

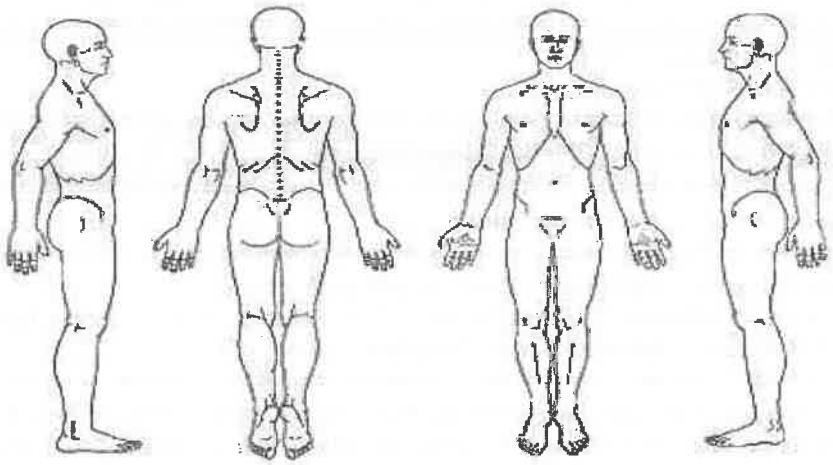
Activities/Movements that are painful to perform: □ Sit □ Stand □ Walk □ Bend □ Lay

Are you currently under care with a health care provider for this condition? □ Yes □ No

What treatment(s) have you already received for your condition?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic □ Acupuncture □Other_____

Massage Therapy

Please indicate the area(s) you would like your massage therapist to focus on.



Health History

Please ☒ if you had or currently have any of the following condition(s).

☐Anemia ☐Anorexia ☐Appendicitis ☐Arthritis ☐Asthma ☐Blood Clots ☐Breathing Difficulty ☐Bursitis ☐Bronchitis ☐Bulimia	☐Cancer ☐Chemical Dependency ☐Diabetes ☐Emphysema ☐Epilepsy ☐Fibromyalgia ☐Fractures ☐Glaucoma ☐Head Injuries ☐Heart Disease	☐Hepatitis ☐Hernia ☐Herniated Disk ☐Herpes ☐High Blood Pressure ☐HIV/AIDS ☐Jaw Pain/TMJ ☐Lymes Disease ☐Lymphedema ☐Migraines	☐Mono ☐MS ☐Osteoporosis ☐Pacemaker ☐Parkinson's ☐Pinched Nerve ☐Pneumonia ☐Polio ☐Prosthesis ☐Rheumatoid Arthritis	☐Sinus Problem ☐Stroke ☐Tendonitis ☐Thyroid Issue ☐Tuberculosis ☐Tumor ☐Ulcer ☐Varicose Vein ☐Whiplash ☐Other_____ _____

Are you currently pregnant?	☐No ☐ Yes - Due Date_____

List Current Medications/Vitamins/Herbs:

List any history of surgical procedures:

List any allergies:

Do you have sensitive skin? ☐ Yes ☐No	Are you sensitive to lotions/oils? ☐ Yes ☐ No

To the best of my knowledge the above information is complete and correct. I understand that massage therapy services are for the primary purpose of short-term relaxation and relief of muscular tension. I understand that massage therapy services are in no way a substitute for exam, diagnosis, or treatment by a health care provider. I understand that the individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from an individual performing massage therapy services is educational in nature, should be used at my own discretion and should not replace the advice of my primary health care provider.

_____ _____

Signature of Client/Parent/Guardian/Representative Date

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal health information such as name, address, and phone number to contact you with appointment reminders.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Our right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	