Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name_____ Date of birth_____

Address_____

State_____ City_____ Home Phone _____

Work Phone _____ Occupation _____

Have you ever received massage therapy? _____ Yes _____ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.)_____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications_____

_____

_____

Are you currently seeing a healthcare professional? _____ Yes _____ No

If yes, please list names and reason/treatment_____

_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___bruise easily
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition*
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder
___depression, panic disorder, other psych condition
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy
___scoliosis
___seizures
___whiplash
___chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share,

please do so:_____

_____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain

_____ anything contagious _____ injuries/bruises

Do you have any allergies to:

_____ medications _____ foods (nuts, etc.)

_____ environmental allergens (dust, pollen, fragrances)

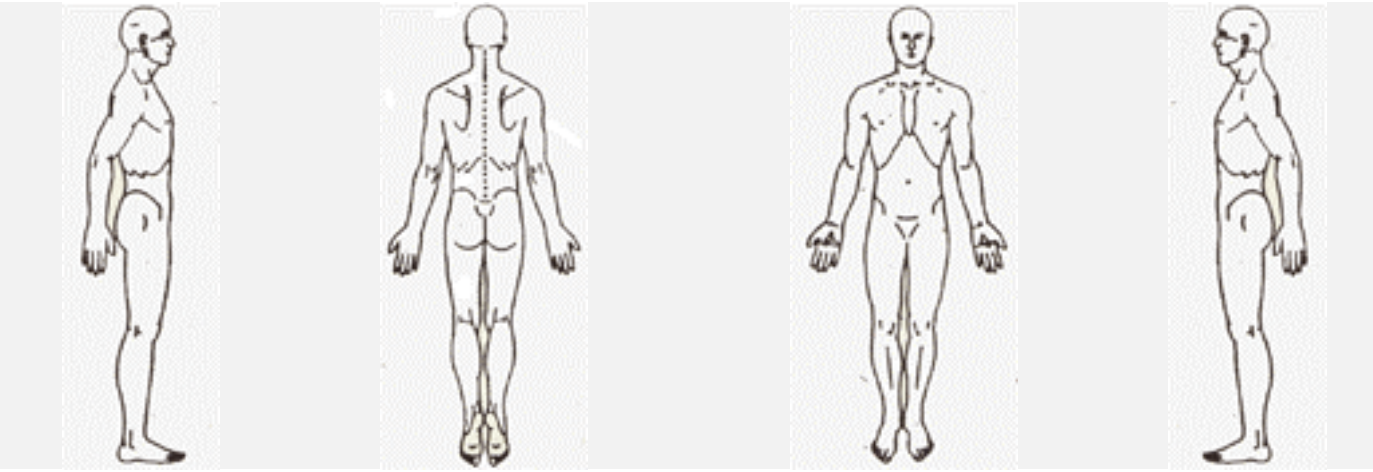
_____ reactions to skin care products

If any of the above are checked, please give details: _____

_____

Are you wearing: _____contact lenses _____ hearing aid _____ hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?_____

_____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:
need to move or change position ❖ sighing, yawning, change in breathing
stomach gurgling ❖ emotional feelings and/or expression
movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature:_____Date_____

Massage Therapy Missed Appointment Policy

Our office strives to provide top-notch quality massage therapy in a timely manner. Coniglio Massage Therapy's missed appointment policy is as follows. No missed appointment fee will be applied if we are notified at least 3 hours prior to an appointment. A $35 missed appointment fee will apply for 1-hour massages. A $20 missed appointment fee will apply for 30-minute massages. Our office asks that you extend common courtesy to our office, massage therapist and other patient's who may wish to schedule during that time.

_____ _____

Name Date

Coniglio Chiropractic, LLC 1144 Mantua Pike, Mantua, NJ 08051 856-468-4200 856-468-2233 info@greatspine.com	**Authorization to Release Protected Health Information**	**For Office Use Only** **PHI:** □ Mailed □ Picked Up □ Faxed **ID Verified:** □ Yes □ No **Date Received:** _____ **Date Processed:** _____ **Processed By:** _____

Please complete this form in its entirety so that we may fulfill your request promptly.

Patient's Name: _____ **Date of Birth:** _____

Street Address: _____

City/State/Zip: _____

Telephone #: _____ **Fax#:** _____

Email Address: _____

Authorization for use/disclosure of information:

I am the patient, or legally authorized representative of the patient, listed above. I voluntarily authorize and direct my health care provider _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below:

□ **Myself**

□ **Another Individual:** _____

□ **Facility/Company/Organization:** _____

Street Address: _____

City/State/Zip: _____

Telephone#: _____ **Fax#:** _____

Email Address: _____

Information to be disclosed:

This authorization permits the above provider to disclose the following medical records:

□ **My complete patient file, including information relating to any medical history, mental or physical condition and any treatment received by me.**

□ **All of my health information described above except for the following:** _____

_____

□ **Only records for dates of service from** ___/___/___ **to** ___/___/___

□ **Only records related to a specific event, incident or illness (please describe or indicate date of event, incident or illness)** _____

□ **Only the following types of information (please check all that apply):**

- □ **History and Physical**
- □ **Clinic Notes**
- □ **Lab Reports**
- □ **Radiology Reports**
- □ **Radiology Images**
- □ **Billing Information**

Inspect/Copy:
I understand that I have the right to inspect or copy the protected health information to be used or disclosed under this Authorization.

Term:
This Authorization will remain in effect:

□ **From the date of this Authorization until** __/__/_____

□ **Until the Provider fulfills this request.**

□ **Until the following event occurs:**_____

If none of the above are indicated, then this authorization will expire 60 days from the date of signature.

Redisclosure:
I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

Refusal to sign/right to revoke:
I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation:
I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Coniglio Chiropractic, LLC at 1144 Mantua Pike, Mantua, NJ 08051]. The revocation will be effective immediately upon the clinic's receipt of my written notice, except that the revocation will not have any effect on disclosures that relied upon this Authorization and were made prior to receipt of the my written revocation.

Questions:
I may contact Coniglio Chiropractic, LLC with questions about the privacy of my health information at 1144 Mantua Pike, Mantua, NJ 08051 by telephone at 856-468-4200, or by email at info@greatspine.com.

_____ _____ _____

Signature **Date** **Printed Name**

If the patient is unable to sign this Authorization, please complete the information below. By signing this form for someone else, you - as the parent, guardian, a party acting in loco parentis, or legal representative - are indicating that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

_____ _____ _____

Name of Guardian/Representative **Date** **Legal Relationship**

Note: This Authorization does not extend to HIV testing or results, psychotherapy notes, or drug or alcohol treatment records that are protected by federal law.