Client Health History Form

Mind & Muscle Medicine, LLC
www.mindandmusclemedicine.com

Name_____ _____
Please Print

Address_____ _____ City _____ ___

State_____ Zip_____ Phone: Home __ _____ Work _____

Cell _____

Would you like to receive text message reminders for your future appointments? Y / N
Date of Birth_____ Occupation_____

Referred by: _____ Email Address_____

Have you had massage therapy/bodywork in the past? ___Yes ___ No How long ago? _____

What is the reason for your visit today? _____

Are you under the care of a physician or other health care practitioner? _____

Are there any areas you want to avoid having treated? _____

Have you had any surgeries? ___ Yes ___ No If yes, please explain: _____
_____

List any medication you are now taking and what they are used for: _____
_____

Do you have a history of any of the following? (Check all that apply)

_____Serious injuries	**_____Bursitis**	**_____Back pain**
_____Headaches	**_____Allergies**	**_____Allergy to nut oils**
_____Arthritis	**_____Skin infection**	**_____Contagious conditions**
_____Pregnant	**_____Recent surgery**	**_____Heart Attack**
_____Blood clots	**_____Stroke**	**_____Diabetes**
_____Low blood pressure	**_____High blood pressure**	**_____Sports Injuries**
_____Varicose veins	**_____Lymph Nodes Removed**	**_____Other:**

I understand that the Massage Therapist at Mind & Muscle Medicine will provide the massage treatment I will receive. All massage treatments are for medical or therapeutic purposes and any technique applied is within our scope of practice. Any information provided on this form will be used to provide you with the best level of care. The therapist throughout the treatment will maintain full sheet draping. The treatment room is clean and reset after each massage and all equipment is maintained in good working order. The client's privacy will be respected while dressing and undressing. The client may request to modify or terminate the treatment at any time. By signing below I acknowledge that the information above is true to the best of my knowledge and that I may receive a copy of the Privacy Policy.

SIGNATURE _____ **DATE** _____

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Acknowledgement of Privacy Rights

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 the treatment directly or indirectly.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my provider'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 such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact the massage clinic to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that the massage therapy clinic restrict how my private information is used or disclosed to carry out treatment, payment or other health care options. I also understand that the massage therapy clinic is not required to agree to my restrictions, but if the massage therapy clinic agrees then all parties involved are bound to abide by such restrictions.

Clients Name: _____ Date: _____

Signature: _____

Parent or Legal Guardian: _____

Relationship to Client: _____if other than parent or legal guardian.

Thank you for your cooperation.
Mind & Muscle Medicine, LLC

Therapist Signature: _____ Date: _____

Unable to obtain the clients written acknowledgement of the Notice of Privacy Rights due to the following: _____