NATURAL HEALTH ASSOCIATES
Your Choice For Proactive Healthcare

Massage Intake Form

Name: _____ Date of birth: _____ / _____ / _____

Address (street): _____

City: _____ State: _____ Zip:_____ Phone: (_____) _____ - _____

Email Address: _____ Newsletter opt-out ☐

Occupation: _____ Employer: _____

Emergency contact name & phone: _____ (_____) _____ - _____

How did you hear about us? _____ *We have a referral program!*

Medical Information

Are you taking any medications? ☐ Yes ☐ No

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ Yes ☐ No

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

Have you had any orthopedic injuries? ☐Yes ☐ No

If yes, please list _____

Please indicate any of the following that apply to you

☐Cancer	☐ Fibromyalgia
☐Headaches/Migraines	☐ Stroke
☐Arthritis	☐ Heart attack
☐Diabetes	☐ Kidney dysfunction
☐Joint replacement(s)	☐ Blood clots
☐High/low blood pressure	☐ Numbness
☐Neuropathy	☐ Sprains or strains

Massage Information

Have you had a professional massage before?

☐ Yes ☐No

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐Medium ☐Deep

Do you have any allergies or sensitivities? ☐Y ☐ N

Please explain _____

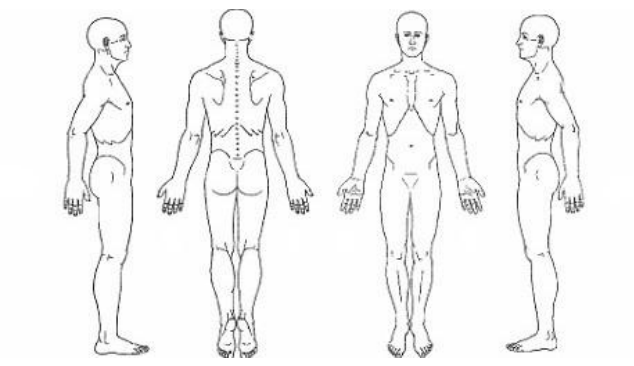
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

Specify: _____

What are your goals for this treatment session?

_____

Circle any areas of discomfort



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Consent for Treatment

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Natural Health Associates (NHA) group of providers includes: Fort Collins Family Acupuncture, Colorado Center of Health and Nutrition, Gonstead Chiropractic, and Rocky Mountain Natural Medicine. The Thermogram Center also works in conjunction with NHA. In order to provide you with the best and most complete care possible, your information may be shared between providers as appropriate.

Name of Client **Signature** **Date**

If client is under 18:

I _____, certify that I am the parent or legal guardian of _____, who is _____ years of age as of today. I have completed the Intake Form for the above mentioned minor and informed the therapist of any and all relevant medical history and concerns. I understand the scope of massage therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms.

Parent or Guardian **Signature** **Date**

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NOTICE OF PRIVACY PRACTICES (HIPAA) (This summary describes how we use and share information about you. This summary describes how you may see and get copies of this information.) This notice includes all occupants of Natural Health Associates.

OUR COMMITMENT TO RESPECT PRIVACY:

Natural Health Associates is required to:

• Keep your information private

• Let you know if we cannot do what you have asked us to do with your information.

• Try to reach you at another location or phone number, if you ask us to do so.

• Use and/or give out your information as listed below and as the law permits, unless we have your permission to do more.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR:

• Treatment: Such as when our providers and employees discuss your care.

• Payment: Such as when we bill your insurance company for services provided to you.

• Other Ways: Such as when we share information to protect the health and safety of others or you; when we send disease reports to county and state health offices as required by law; when we provide information to researchers, organ donation groups, or funeral directors; and when we respond to court requests. We may also send you appointment reminders, greeting cards, and newsletters.

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION:

You have the right to:

• Ask for restrictions on the ways we use and give out your information. However, we are not required to do what you ask, where the law requires otherwise.

• Get and inspect a copy of your health record.

• Add information to your health record.

• Ask that your health information be sent to a different address or that we call you at a different phone number.

• Change your mind if you told us we could use or share your information for reasons other than those listed above.

• Get a list of the times we gave out your information (this will be a list of the times the law requires us to keep a record of releasing your information). As we serve our clients, we may modify what we do with your information. If we make a change, we will give you a new notice the next time you visit us. You may call or write us to inquire about any changes.

Name of Client	**Signature**	**Date**

Parent or Guardian (if client is under 18)	**Signature**	**Date**

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, NHA and its associates reserves the right to charge a fee for all missed appointments ("no shows") and appointments that, absent a compelling reason, are not cancelled with 24-hour advance notice.

This fee may be waived if the patient reschedules their missed service to take place within 48 hours.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple 'no shows' in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature