Image Sculptors

Plastic Surgery Medical Day Spa

Jacqueline Smith – Massage Therapist

PERSONAL DATA:

Full name: ______________________________

Address: ______________________________

City: ______________________________

State: _______ Zip: ________

Date of birth: ________________ Age: _______ Sex: __________

SS#: ________________________

Home Phone: _______________________ Work Phone: _______________________

Cell phone: _______________________

Which phone should we contact you on?

____

May we leave messages on this phone? Y ___ N ___

RESPONSIBLE PARTY (for minors under 18):

Name: ____Relation to patient: ____________________________

Address: ____________________________________ City: ______________State: ______Zip: ______

Daytime phone: __________________ Evening phone: __________________ Cell phone: ______________

EMERGENCY CONTACT:

Name: ______________________________________ Relation to patient: ____________________________

Work Phone:__________________________________ Home Phone:___________________________________

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MEDICAL INFORMATION

Yes No *Have you had a massage before?*

If yes, how recently? ____

Yes No *Do you frequently suffer from stress?*

Yes No *Do you have tension or soreness (including sprains/strains) in a specific area? Please specify:*____

Yes No *Do you suffer from neck or back pain?*

Yes No *Do you have numbness or stabbing pains anywhere?*

Where? ____

Yes No *Are you very sensitive to touch or pressure in any area?*

Yes No *Do you exercise? Please list activities, frequency, and intensity:*

____

Yes No *Do you have cardiac or circulatory problems?*

Yes No *Do you have high blood pressure?*

If yes, do you take medication? Yes / No

Yes No *Do you or have you ever suffered from blood clots?*

Yes No *Do you have varicose veins? Where:* __________________________

Yes No *Do you have diabetes? If yes, is it controlled?* ________________

Yes No *Do you experience frequent headaches?*

Yes No *Are you pregnant?*

Yes No *Do you suffer from arthritis? Where:* _________________________

Yes No *Do you suffer from joint swelling? Where:* ____________________

Yes No *Do you have osteoporosis?*

Yes No *Do you suffer from epilepsy or seizures?*

Yes No *Do you have, or have you ever had, cancer? Type* ________________

Yes No *Do you or have you had any contagious diseases in the last 48 hrs prior to massage?*

Yes No *Do you have any skin conditions?*

If yes please explain ____

Yes No *Do you bruise easily?*

Yes No *Have you had any broken bones in the past two years? Please list:*

Yes No *Have you been in an accident or suffered any injuries in the past three years? If yes please explain on back.*

Yes No *Have you ever had surgery? Please explain:* ___________________

____

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Yes No *Do you have any other medical conditions not mentioned here?*
If yes, please describe? ____
Yes No *Do you have other concerns your massage therapist should be aware of? Please explain:*

Yes No *Do you have any allergies? Please list allergies* _________________

MEDICATION INFORMATION SHEET

Medication	Condition For

Please understand that there are medications and medical conditions that are contraindications to a massage. If you have any medical conditions or are on medications that may be a contra indicator please call our office and ask, as this may save you time. We will be happy to answer your questions.

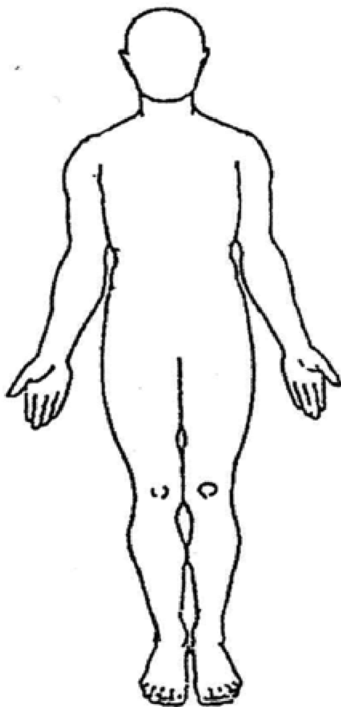
SHOW ME WHERE IT HURTS!

Please mark the areas of the drawings according to where you hurt. Be sure to make your marks according to how you feel at the time you are filling out the form. (If you feel pain in your back, mark the back of the drawing, etc.) Use the key below to map your symptoms.

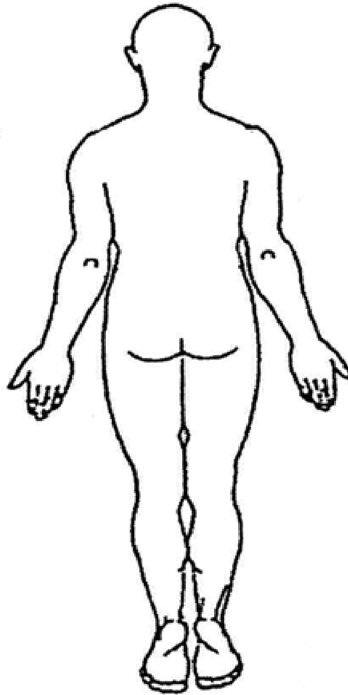
Symptoms:

NUMBNESS	PINS & NEEDLES	BURNING	TENSION	SHOOTING
=======	+++++++	////////	xxxxx	>>>>>

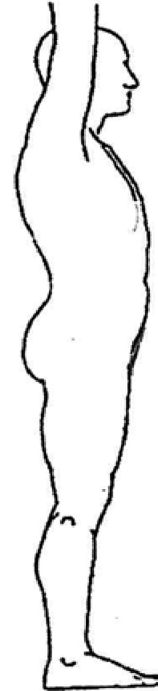
front



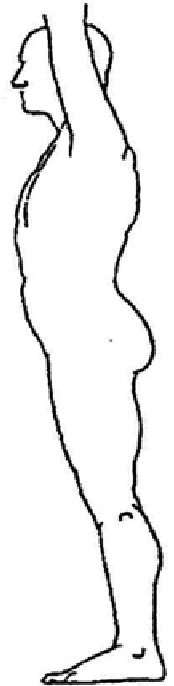
back



right



left



Any comments you may have to help us understand your pain:

____

____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by ***Image Sculptors at ADC*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***Image Sculptors at ADC***. I understand that diagnosis or treatment of me by Dr.Bennett may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***Image Sculptors at ADC*** is not required to agree to the restrictions that I may request. However, if ***Image Sculptors at ADC*** agrees to a restriction that I request, the restriction is binding on ***Image Sculptors at ADC*** and Dr.Bennett. I release all medical records to Dr.Bennett, and all records created at if ***Image Sculptors at ADC*** are the property of Dr.Bennett.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr.Bennett or ***Image Sculptors at ADC*** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ***Image Sculptors at ADC*** 's Notice of Privacy Practices prior to signing this document. The ***Image Sculptors at ADC***'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***Image Sculptors at ADC***. This Notice of Privacy Practices also describes my rights and the ***Image Sculptors at ADC*** 's duties with respect to my protected health information.

Image Sculptors at ADC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the ***Image Sculptors at ADC***'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____________________________________ __________________________
Signature of Patient or Personal Representative | Date

____________________________________ __________________________
Print Name of Patient or Personal Representative | Description of Personal Representative's

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PLEASE INITIAL THE FOLLOWING SATEMENTS: **INITIAL**

1) I am aware that draping will used during the massage session. ________

2) I understand that it is not within the scope of the massage session for the therapist to engage in breast massage on female clients. ________

3) I understand that *my* feedback is an essential element in my treatment, therefore if at any time I should be become uncomfortable during the massage, I may bring it to my therapist's attention and request that the session end. ________

The following type(s) of massage techniques may be used in the therapy session.

Shiatsu	Trigger Point	Reiki
Swedish	Deep Tissue	Sports
Stretching	Accupressure	Hot Stone
Reflexology	Craniosacral	Myofascial
Prenatal		

PLEASE READ THE FOLLOWING STATEMENTS, THEN SIGN AT THE BOTTOM OF THE PAGE

I have read and fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional massages.

The massage treatment given here is for the sole purpose of stress reduction, relief from muscle tension or spasm and to increase circulation and energy flow.

The Massage Therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder.

The Massage Therapist does not do spinal manipulations. Massage Therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have.

It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job. Your Massage Therapist is an independent professional and is solely responsible for your treatment.

______________________________ ______________________________

Client Signature Massage Therapist Signature

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