CLIENT INFORMATION SHEET

Patient Name _____ Birth date _____ Age_____ Sex M /F

Address _____ City _____ State _____ Zip _____

Primary Phone (_____) _____ Email _____

Occupation _____ Employer _____ Work Phone (_____) _____

Emergency Contact _____ Phone (_____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ☐No ☐Yes, last massage:_____

Please check all of the following that apply to you:

☐ Accidents/injuries in the last two years
☐ Any type of contagious disease
☐ Arthritis
☐ Broken bones in the last two years, please list:_____
☐ Cardiac or circulatory problems
☐ Currently pregnant, _____weeks (#)
☐ Currently wearing contact lenses
☐ Currently wearing dentures
☐ Diabetes
☐ Epilepsy/Seizures
☐ Frequent headaches
☐ Frequently suffer from stress
☐ High Blood Pressure, and currently taking medication
☐ Joint swelling
☐ Numbness/stabbing pain, where:_____
☐ Osteoporosis
☐ Prone to bruising
☐ Sensitive to touch/pressure, please indicate where: _____
☐ Surgeries _____
☐ Tension/soreness in any area, please indicate where: _____
☐ Varicose veins
☐ Other Health Problems _____

Please mark all that apply of the services provided by this office that interest you

☐ Injury prevention ☐ Weight management ☐ Spinal and body alignment/posture ☐ Acupuncture
☐ Treatment for pain ☐ Wellness care ☐ Strengthening and stamina exercise ☐ Chiropractic
☐ Nutritional genetic testing ☐ Nutritional counseling ☐ Patient education workshops

If you are new to this office, how did you hear about us? ☐ Newspaper/phone book ☐ Insurance provider list
☐ Friend/family (name): _____ ☐ Other (specify): _____

Are you currently taking any medications? (*Write on back side for additional space*)

Medication Name	Dosage and Frequency (i.e. 5mg one a day, etc.)

Do you have any allergies?

Allergy	Reaction	Onset Date	Additional Comments

I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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 of which I am aware. **I understand that massage/bodywork practitioners 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/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.** ***I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. If I neglect to notify Lifestyle Chiropractic & Wellness of a cancellation within 24 hours or am late to my appointment, I acknowledge my responsibility to pay for services for which I was scheduled (minimum cancellation fee of $25).***

Client Signature/Guardian Signature_____ Date _____

Consent to treatment of minor: By my signature below, I hereby authorize the practitioner to administer massage, Bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Practitioner Signature_____ Date _____

For office use only
Height_____
Weight_____
BP _____ / _____

NOTICE OF PRIVACY PRACTICES

Patient Name: _____

TO THE PATIENT: This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Do research
- Discuss your case with family
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Reporting to law officials
- Court hearing and filings
- Reporting to worker's compensation
- Health and safety reasons
- Reporting victims of abuse

You have the right to:

- Request a copy of your health record
- Amend your protected health information
- Ask us to limit the information we share
- Request a list of persons with whom we share your health information
- Request confidential communications
- Advise our staff if you believe your privacy rights have been violated

These privacy practices are effective October 2014.

We may recommend you use, as a part of our treatment program, one or more nutritional supplements. We recommend this supplement or these supplements because we believe your health will benefit from your use of them. We want you to know that, because of our belief in the integrity and effectiveness of these supplements, we are a distributor of these products and, in that role, we may receive a commission from your purchase of these supplements. Please ask to speak with us if you have any concerns about our recommendations in light of this information. For further information please contact the front desk.

EMAIL AND SOCIAL MEDIA DISCLAIMER

Lifestyle Chiropractic & Wellness does not have an email address that is checked regularly and therefore will not be held liable for unanswered emails. For your protection, we also ask that you refrain from sending emails or posting information on social media containing personal health information as our health professionals will not respond.

RELEASE OF LIABILITY

Lifestyle Chiropractic & Wellness requests your permission to use you in any audio, video, and/or photography for the purposes of promoting Lifestyle Chiropractic & Wellness through any type of media including, but not restricted to websites, print, blogs, social networking, etc. This permission will be granted without restriction, and Lifestyle Chiropractic & Wellness will be held harmless from any claim, lawsuit, or further liability concerning the types of media mentioned above. Be assured, no personal health history or contact information will be divulged unless specifically authorized by you.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, DISCLAIMER AND RELEASE OF LIABILITY

You may refuse to sign this document.

I have read, or have had read to me, the above explanation. I have discussed it with the staff at *Lifestyle Chiropractic & Wellness* and have had my questions answered to my satisfaction. By signing this document, I grant the above mentioned permission to Lifestyle Chiropractic & Wellness. Having been informed, I hereby acknowledge my rights of privacy and understand this disclaimer.

I, _____, have received a copy of the notice of privacy practices of the above named office.

_____ _____

Patient's Signature (Guardian's Signature If Patient Is a Minor) **Date**

Lifestyle Chiropractic & Wellness
Restoring and Maintaining Optimal Health Naturally...

Phone: (951) 929-0100