Massage Intake

8791 Wolff Ct. Suite 140
Westminster, CO 80031
PH: 303-427-2414
FX: 303-427-5719

Name:_____ DOB:_____ Age: _____ Sex: M / F

Address:_____ City:_____ ST:_____ ZIP:_____

Home Phone:_____ Mobile Phone:_____ Preference: ☐H ☐M

Email Address:_____
(By providing your email you consent to being added to our mailing list for announcements)

Emergency Contact:_____

Relationship:_____ Contact Phone:_____

Employer:_____Occupation:_____

How did you hear about our office? (Who referred you)_____

Automated Reminders (Choose one)
☐Text: Mobile Phone Provider:_____ ☐ 1 Day Prior ☐ 2 Days Prior
☐Email

What type of treatment are you looking for? (Check all that apply)

- ☐ Quick Fix. I want the minimal amount of care to "patch up the symptoms" of my problem.
- ☐ Problem Fix. I want to resolve the symptoms and go on to "fix the cause" of my problem.
- ☐ Optimal. I want to take care of my current problems then go on to "achieve optimal health".

Please describe the current condition that brings you to our office: _____
_____
_____

When did the condition start: _____

Is the condition getting worse? ☐ Yes ☐ No

Is this condition interfering with your: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Other:_____

Are there any specific areas of concern/pain?: _____
_____
_____

Are there areas you would prefer we avoid?_____
_____
_____

Check all that apply: PAST (P) OR CURRENT (C)

Musculoskeletal System	**P**	**C**	**Nervous System**	**P**	**C**
Low Back Pain			Sore Muscles		
Mid Back Pain			Weak Muscles		
Pain b/w Shoulders			Walking Problems		
Neck Pain			Spasms		
Arm Problems			Broken Bones		
Shoulder Pain			TMJ (Jaw Pain)		
Leg Problems			Teeth Grinding		
Ankle/Foot Pain			**Nervous System**		
Wrist/ Hand Pain			Headaches		
Swollen Joints			Muscle Jerking		
Painful Joints			Confusion		
Stiff Joints			Forgetful		

Medications: Please list your current medications including “over the counter” medications and nutritional supplements.

Name of Medication:	Dose:	Reason for taking:
1.		
2.		
3.		
4.		
5.		

Allergies:

Food: _____

Seasonal: _____

Environmental: _____

Medications: _____

Other: _____

Have you had any surgeries?: _____

_____

_____

Family History: G=Grandparent, M=Mother, F=Father, S=Sibling

Stroke:_____ Fainting: _____

Seizures: _____ Other (Explain): _____

Are you suffering from or been diagnosed with:
PTSD: _____

Seizures: _____

Contagious Ailments (IE; Athlete's foot, Cold, Flu…): _____

Women: Are you pregnant? _____

Privacy Policy:
We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records are used.

1. The patient understands and agrees to allow NFHC to use their PHI for treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written consent.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by NFHC to assure that your records are not readily available to those who do not need them.
6. If a patient has a complaint about the privacy of records, please contact Michaele, our office manager.
7. If the patient refuses to sign this consent, our office has the right to refuse care.

I have read and understand how my PHI will be used and I agree to these policies and procedures. Please let us know if you would like a full copy of the office "Notice of Patient Privacy Policy".

Signature: _____ Date: _____
Printed Name: _____

Permission to Communicate Protected Health Information:

I, _____ DOB: _____, grant permission for Natural Family Health Care, Inc. to disclose my health information as specified below:

I authorize the providers of NFHC to speak about my care with:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

***I understand this may include detailed personal medical information including, but limited to: medical services to be provided, notification of supplements to be picked up, or appointments to be scheduled.**

_____ Date: _____
Signature of Patient or Authorized Representative

This consent form will expire when revoked in writing by the patient/representative or, in the case of a minor, on the date the minor becomes an adult under state law.

Consent for Professional Services:
I hereby authorize the employees of Natural Family Health Care, Inc. to leave a detailed voicemail/email regarding my services at any contact information given, knowing that it will identify me as a patient of the office. I also give permission to disclose my presence in the office to friends and family calling or coming in, for the purpose of scheduling or supplemental requirements.

_____
Signature of Patient or Authorized Representative

Financial Policy

I understand that Natural Family Health Care is not a provider for any insurance companies, other then Medicare.
I clearly understand that all services and products rendered to me are my personal responsibility. If this financial agreement is not paid when due, I agree to pay all reasonable costs of collections including but not limited to court costs, and attorney's fees.

****Any missed appointments without 24 hour prior cancellation notice will be charged the full amount of the visit.****

_____ Date: _____
Signature of Patient or Authorized Representative