Stillpoint
Therapeutic Massage
& Bodywork

CLIENT INFO & CONSENT

I _____ give consent to Stillpoint Therapeutic Massage & Bodywork, LLC for the use and disclosure of my Protected Health Information (PHI) for the specific purpose of providing treatment tome, receiving payment for services rendered tome and for general administrative operations of the practice.

I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions. If the practice agrees with my restrictions, the restriction is binding on the practice.

You may contact me for appointment reminders, schedule changes, or other needs by the following methods:

Home Phone _____ Home Address _____

Cell Phone _____ _____

Email _____ City _____

Work Phone _____ State _____ Zip Code _____

Appointment Rescheduling & Cancellations:

There is no cost for rescheduling appointments within 24 hours of the appointment. I agree to reschedule if I am experiencing cold or flu-like symptoms. Cancellations with at least 24 hours notice will not be charged. Cancellations with less than 24 hours notice will warrant payment for the scheduled appointment. I agree to pay for the appointment in such an instance. Initial _____

Marketing:

Occasionally we send out newsletters, announcements and special occasion cards. If you do **not** wish to receive these, please check here: ☐

How did you hear about Stillpoint? _____

I have received a copy of the Privacy Policy Notice. I have read the Notice and understand this authorization form. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying Stillpoint Therapeutic Massage & Bodywork, LLC in writing.

Signature _____ Date _____

Print Name (client or Personal Representative): _____

Relationship to Client and Description of Representative's Authority: _____

PLEASE MAKE SURE TO COMPLETE BOTH SIDES OF THIS FORM. THANKS!

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HEALTH INTAKE

Name _____ Date _____ DOB _____

HEALTH INFORMATION: List health concerns. Please include treatment, medications and progress.

_____

_____

Check all conditions that you are currently experiencing.

- □ Headaches
- □ Cold/Flu
- □ Fever
- □ Contagious Disease
- □ Infection
- □ Skin Rash
- □ Arthritis
- □ High Blood Pressure
- □ Heart Disease
- □ Asthma/ Breathing Difficulty
- □ Digestive Problems
- □ Diabetes
- □ Sleep Disturbances
- □ Pregnancy
- □ Allergies
- □ Cancer
- □ Other

Please explain any of the above checked conditions.

_____

_____

List and explain. Include dates and treatment received.

Surgeries _____

Accidents/Injuries _____

Major Illnesses _____

DAILY ACTIVITIES: List your daily activities, i.e., work on computer, phone, carry heavy objects, etc.

Work _____

Home/Family _____

Social/Recreational _____

How do you reduce stress? _____

How do you reduce pain? _____

Have you received massage/ manual therapy before? _____ When? _____

Please describe _____

What are your goals for receiving massage therapy? _____

I acknowledge that the above information is complete and accurate to the best of my knowledge.

Signature _____ Date _____