Milestone Massage
745 S. Church St
Murfreesboro, TN 37130
615-485-4553

Medical History/ Client Information Form

Name_____ Male ( ) Female ( ) DOB_____

Home Phone_____ Cell _____ Work _____

Email _____ E-mail Opt-in Specials ☐

Address_____

City_____ State_____ Zip_____

Occupation _____ Employer _____

Emergency Contact Person _____ Phone _____

Please describe any previous experience with massage _____

Reason for today's appointment (i.e. relaxation, tightness, pain relief, ect.) be specific please

_____

_____

How did you hear about Milestone Massage? ( ) Ad ( ) Flyer ( ) Facebook / My Space

( ) Friend_____ ( ) Other _____

Medical History: Please check all that apply:

__High Blood Pressure	__Low Blood Pressure	__Heart Disease	__Stroke
__Diabetes	__Varicose Veins	__Phlebitis	__Cancer
__Asthma	__Headaches	__Fibromyalgia	__Gout
__ Spinal Problems	__Infections	__Endocrine Disorder	__Stress
__Cuts, Bruises, Fractures	__Skin Disorders	__Bursitis	__Surgeries
__Respiratory Problems	__Epilepsy/Seizure Disorders		__Gastrointestinal Problems
__Reproductive Problems	__Psychological Disorders		__Musculoskeletal Disorders
__TMJ Dysfunction	__Arthritis (Location_____)		
__Accidents	__Pregnancy (How far along are you_____)		

Please explain any checks above:

_____

_____

Please list any allergies: _____

Current Medications and reason for taking: _____

_____

Are you currently under a physician's care? ( ) Yes ( ) No If Yes why? _____

_____

Do we have Permission to contact if need arises? ( ) Yes ( ) No

Doctors Name _____Phone Number_____

Intake Per Day caffeine_____ Alcohol _____ Tobacco _____

What are your goals/expectations for this therapy session?

_____

_____

Physical Pain Assessment

Where is your pain? _____

How long have you had this pain? _____

What helps your pain? _____

What makes your pain worse?

_____

Does your pain interfere with normal activities? _____

Describe your pain in your own words _____

On a scale of 1-10 (1 =no pain, 10= severe pain) which best describes your pain. _____

Where is your pain now? _____ Where is your pain at its best? _____ Worst? _____

Is there anything else you would like me to know? _____

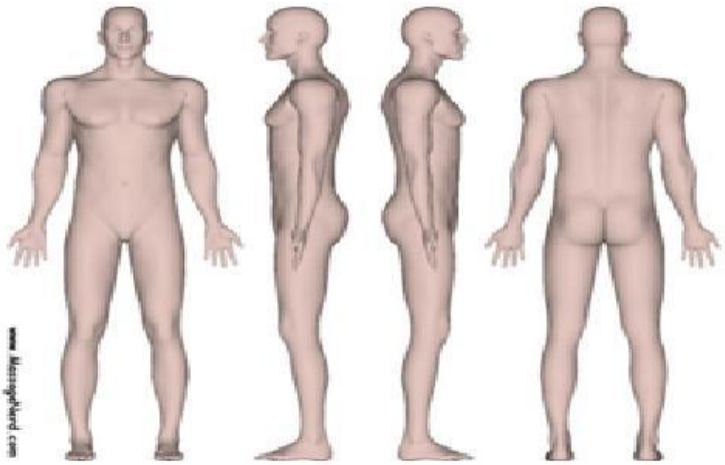
_____

_____

Physical Activity: ___Light ___Moderate ___Heavy

How Often Do You Exercise? _____ What Type? _____

Please mark all the trouble areas.



PLEASE READ AND SIGN

I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for medical purposes. I authorize Milestone Massage to obtain any information from my primary health care providers concerning my health if necessary. I clearly understand that massage therapy treatments are my personal financial responsibility, and I agree to pay for these services at the time of treatment, unless other arrangements have been made. I understand that I will be charged for any appointment broken with less than 12 hours' notice or prior arrangements.

SIGNATURE_____ DATE _____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:

*need to move or change position *sighing, yawning, change in breathing
*stomach gurgling *emotional feelings and/or expression
*movement of intestinal gas * energy shifts * falling asleep *memories

Please read the following information and sign below:

I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.

Draping will be used during the session – only the area being worked on will be uncovered.

I, _____ (print name) 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.

Signature of client_____ Date _____

Signature of Massage Therapist _____Date _____

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.

Privacy Practices

I was offered a copy of Milestone Massages Privacy Practices.
I have read and understood these practices.

This notice has been issued and considered effective date signed. This copy shall be retained by the department for a minimum of six (6) years.

_____

Signature of Patient or Legal Representative Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)
HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

MY PLEDGE REGARDING YOUR MEDICAL INFORMATION

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situation, the law requires me to disclose your health information without either a written or verbal consent.

USE AND DISCLOSURE WITH CONSENT INFORMATION

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.
I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.
• Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
• Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

USE AND DISCLOSURE WITHOUT CONSENT

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:
- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc.). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.

This notice is effective as of March 17th, 2003, and I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.
For more information about my privacy practices: For more information on HIPPA or to file a complaint:

The US Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington DC 20201
877-696-6775 (toll free)

Milestone Massage
745 S. Church St. Suite 220
Murfreesboro, TN 37130
(615)485-4553

This notice has been issued and considered effective date signed. This copy shall be retained by the department for a minimum of six (6) years.