Karen Small, LMT

Creating space for healing and change

Confidential Health Questionnaire

Name: _____ **Today's Date:**_____

Street Address: _____

City: _____ **State:**_____ **Zip Code:** _____**Home Phone:** _____

Work Phone:_____ **Cell phone:**_____ **Email:** _____

Occupation: _____ **Age:** _____ **Date of Birth:**_____

Referred by:_____ **Marital status?**_____ **Children?** _____

Have you received massage before?:____**If yes, what type and how often?:**_____

_____

Do you have difficulty lying on your front, back or side?_____

What brings you here today? What results would you like to achieve? Is there anywhere you'd like extra time spent? Any place with muscle soreness/tension? Are there areas you'd like me to avoid?:

_____

_____

_____

Daily activities/sports/hobbies/exercise:_____

_____

Do you perform any repetitive movements in your work, sports or hobby?_____

Do you sit for long hours at a computer or driving?_____

Posture assumed most of the day: _____**Do you feel that have a healthy diet?**_____

Daily water intake: _____ **Daily caffeine intake:** _____ **Average hours of sleep per night:** _____

Known allergies (lotion/oil/scents/nuts):_____

Please describe your general health?_____

Have you had any serious accidents/injuries? When? (Including whiplash, sprain, deep bruise, strain, other)_____

_____

How would you describe your general stress level?_____

Do you consume any of the following?:

__Nicotine
__Alcohol
__Illegal substances
__Vitamins _____
__Herbal supplements _____
__Over the counter meds _____

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Medical History

Skin condition (acne, rash, allergies, skin cancer, abscess, open sores, warts, athlete's foot, other)_____

Lymphatic/Immune condition (swollen glands, lymph node removal, leukemia, lymphedema, autoimmune disorder, chronic fatigue, lupus, other)_____

Circulatory condition (heart disease, varicose veins, phlebitis, deep vein thrombosis, arteriosclerosis, high/low blood pressure, hemophilia, anemia, arrhythmia, clotting disorder, easy bruising, other)_____

Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, MS, dizziness, other)_____

Joint problems (osteoarthiritis, rheumatioid arthritis, gout, hypermobile joints, sacroiliac problems, disc problems, TMJ dysfunction, scoliosis, bursitis, other)_____

Bone conditions (osteoporosis, previous fracture, cancer, other)_____

Muscular condition (fibromyalgia, tendonitis, carpal tunnel syndrome, spasms, weak/sore muscles, other)_____

Urinary condition (kidney stones, renal failure, other)_____

Respiratory conditions (emphysema, sinusitis, asthma, tuberculosis, other)_____

Endocrine disorders (diabetes, hyper/hypothyroidism, other)_____

Reproductive condition (breast cancer, endometriosis, ovarian cysts, prostate cancer, painful menstruation, other) _____

Are you pregnant? Are you trying to become pregnant?_____

Digestive disorders (Crohn's disease, ulcerative colitis, IBS, cirrhosis, hepatitis, constipation, other)_____

Headaches (migraines, PMS, tension, cluster, sinus, other)_____

Emotional difficulties (depression, anxiety, psychotic episodes, PTSD, other)_____

Previous surgery (please state type and date)_____

Other medical considerations_____

Do you use/have any of the following? (contacts, wig, dentures, hearing aides, pins, pacemaker)_____

Are you under medical care or supervision?____For what condition? _____

Are you currently taking any prescription medication (name and dose)?_____

_____

Do you use the services of other complementary alternative medicine providers? (chiropractor, naturopath, psychotherapist, physical therapist):_____

Do I have consent to contact your Health Care Provider(s) for consultation if needed?_____

Health Care Provider(s): _____ **Phone Number:** _____

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Consent for Care

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I understand that massage is intended to promote relaxation and circulation, and relieve stress, muscle tension, spasms and related pain. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have informed the Practitioner of all medical conditions that I am aware of and of medications I use. I will inform the Practitioner of any changes in my health status and I release the Practitioner of any liability if I fail to do so. Information exchanged during any session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion. I agree to participate fully as a member of my health care team. I promise to inform the Practitioner at any time if I feel my well-being is threatened or compromised. I expect the Practitioner to provide safe and effective care.

Signature: _____ **Date:** _____

Payment/Cancellation Policy

Payment in full is required at the start of the appointment. Cash and checks are acceptable methods of payment. If you'd like to use a credit card you can "swipe it" using "Square" (www.squareup.com) or you can be emailed an invoice to be paid through PayPal. If payment is refused by the bank or credit agency, any fees accrued by Practitioner are owed by the client to the Practitioner.

Sessions are by appointment only. Any client who is late for an appointment will be charged for the full session, and the session will end at the regularly scheduled time. In the event the client is unable to attend the scheduled session, 24 hour notice must be given to the Practitioner. Any sessions cancelled with less than 24 hours notice, will be charged at the full session rate.

Rates per session:

- 30 minutes: $45
- 60 minutes: $80
- 75 minutes: $95
- 90 minutes: $110
- 120 minutes: $140
- Gratuities are not expected.
- If you feel that you would benefit from my specific skill set but cannot afford my services, please discuss it with me.

I understand and accept the above described Payment/Cancellation Policy.

Signature: _____ **Date:** _____

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Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

My Pledge Regarding Medical Information

The privacy of your medical information is important to me. I understand that your medical information is personal and I am committed to protecting it. I create a record of care and services you receive at my office. I need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways your medical information may be used.

My Legal Duty

The law requires me to:

1. Keep your medical information private.
2. Give you this notice describing your legal duties, and your rights regarding your medical information
3. Follow the terms of this notice that is now in effect.

We have the right to:

1. I may need to change my policies at some time in the future. Before I make significant changes in my policies, I will provide you with a revised copy of this notice. The terms of the new notice will be effective for all medical information that I keep, including information previously created or received before the changes.
2. You may request a copy of my notice at any time.

Use and Disclosure of Your Medical Information

I will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to me.

1. For treatment: I may use medical information about you to provide you with treatment.
2. Notification: I may use or disclose your medical information to notify or help notify a family member or personal representative in the event you become ill or need assistance. I will share information about your location and general condition.
3. Court Orders and Judicial and Administrative Proceedings: I may disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances.
4. Research in limited circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
5. For Payment: A bill may be sent to you. The information on or accompanying the bill may include information that identifies you, as well procedures and supplies used.
6. Communication with Family: I may, using my best judgment, disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
7. Marketing: I may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Your Individual Rights

You have a right to:

1. Look at or get copies of your medical information.
2. Receive a list of instances where I have disclosed health information about your for reasons other than treatment.
3. Request that I place additional restrictions on my use or disclosure of your medical information. I will consider your request, but am not obligated by law to agree to the restrictions.
4. Request that I change your medical information. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that I correct the existing information or add the missing information.
5. Request confidential communications. You have a right to receive confidential communications containing your health information.
6. Have a paper copy of this notice.

Questions and Complaints

If you have any questions about this notice or if you think that I may have violated your privacy rights, please contact me as listed here: Karen Small, 154 S Woody Hill Rd., Westerly, RI 02891 or phone 401-480-6897. You also may send a written complaint to the U.S. Department of Health and Human Services. You may visit www.hhs.gov/ocr for further information.

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Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed and how I may obtain access to and control this information.

Signature of Client or Personal Representative

_____ Date _____

Print Name of Client or Personal Representative

_____

Please list who you want to have access to your pertinent medical information (if anyone)? (i.e.: family member, spouse, significant other)

_____

May I contact you by phone (appointment reminders or cancellation, check-in after appointment)?_____

Preferred number? _____

May I leave a message? _____

May I contact you by mail (typically less than 3 items/year)? _____

May I contact you by email (primarily email newsletter)?_____

Would you like to receive appointment reminders by text message? _____

Who should I contact in case of emergency (name and phone number)?

_____

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