Spinal & Sports CARE CLINIC
Soothing relief for your worst pain

Paul Kays, LMP
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Massage Intake Form

Name _____ Date _____

Street _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Occupation _____ Date of Birth _____

Emergency Contact _____ Phone (_____) _____

Primary Health Insurance _____

Massage History / Treatment Information

Have you ever received a professional massage? **Yes** **No** Date of last Massage _____
What results do you want from your massage sessions? _____

Are there any areas of your body that you do not want massaged?
_____ Head _____ Arms/Shoulders _____ Neck/Upper Body
_____ Abdomen _____ Low Back/Buttocks _____ Legs _____ Feet

List any exercises or activities that makes your condition **better**:_____
_____
List any exercises or activities that make your condition **worse**:_____
_____
List current medications including aspirin, ibuprofen, herbal remedies, etc. _____
_____
Are you currently under the care of a medical doctor? Yes No
If yes, please give name _____

Previous History (Include year and treatment received)

Surgeries: _____
_____

Injuries/accidents still affecting you:
_____
_____

Major Illnesses or Hospitializations:_____

Please turn page over and complete form

Please mark any of the following that you now have or have had. **Circle** *applicable condition where two are listed on same line and* **indicate left or right side and location** *where needed.*

Musculoskeletal

- Bone or joint disease
- Tendonitis / Bursitis __L __R _____
- Arthritis / Gout / Blood Clots
- Sprains / Strains __L __R _____
- Low back / hip / leg pain __L __R _____
- Neck / shoulder / arm pain __L __R _____
- Spasms / cramps
- Jaw pain (TMJ)
- Lupus
- Osteoporosis
- Other: _____

Circulatory

- Heart condition
- Phlebitis / Varicose Veins
- Blood Clots
- High / Low Blood Pressure
- Lymphedema
- Thrombosis / Embolism
- Other : _____

Respiratory

- Breathing difficulty / asthma
- Emphysema
- Allergies
- Sinus Problems
- Other: _____

Skin

- Allergies
- Rashes
- Athletes foot
- Herpes / cold sores
- Other: _____

Digestive

- Constipation
- Gas / bloating
- Diverticulitis
- Irritable bowel syndrome
- Ulcers
- Other: _____

Reproductive

- Pregnant: Stage
- Ovarian / menstrual problems
- PMS
- Prostate
- Other: _____

Nervous

- Shingles
- Numbness / tingling __L __R _____
- Trigeminal / Neuralgia
- Bell's Palsy
- Pinched Nerve
- Other: _____

Other

- Cancer / Tumors
- Bladder / Kidney ailment
- Diabetes
- Drug / Alcohol / Caffeine / Tobacco use
- Chronic fatigue
- Chronic pain
- Sleep disorders
- Migraines / Headaches
- Anxiety / Stress syndrome

Please circle all that apply today:

- Contact lenses (hard or soft?)
- Infection
- Inflammation / swelling
- Fever
- Communicable illness (please specify):

_____

Additional Client Remarks / Comments

_____

_____

_____

Massage therapists must be aware of any existing physical conditions that I have. I have listed all my known medical conditions and physical limitations and will inform the massage therapist in writing of any change in my physical health. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or emotional disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have. I also agree to give 24-hour notice if I must cancel my appointments for these sessions.

Signed _____ Date _____

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MASSAGE CLINIC POLICIES

Financial Policy:

_____ I understand that I will be required to pay for my massage services at the time of my appointment.

_____ I understand that my insurance will be billed for massage therapy services and that I will pay all deductible and patient responsibility payments prior to seeing the therapist. I also understand that if my insurance denies payment for any reason, I will be responsible for the balance due on my services at that time. Any dispute with the insurance company regarding covered services will be my responsibility to resolve.

_____ I understand that if a referral/prescription from my treating physician is required by my insurance, our clinic will make every effort to *assist* me in obtaining it. However, if the referral is not in place at the time of my visit I will be rescheduled. A referral or prescription does not guarantee insurance payment. All services billed to insurance are based upon medical necessity to be determined by the insurance company upon receipt of your claim for services provided.

_____ *If I am unable to pay at the time of service, I will be rescheduled for a more convenient time.*

_____ I understand that any massage benefit information given to me by the staff at SSCC is an *ESTIMATE only* of benefits as quoted to them by the insurance company. The office does not guarantee the correctness of the information. It is my responsibility to know and understand my massage benefit.

No Show Policy:

_____Our clinic requires a 24-hour notice for cancellation of all massage appointments. If I am unable to give this notice or I fail to keep my appointment I will be charged a *"No Show"* fee which will be expected to be paid within 24 hours and prior to scheduling any future appointments. *The no show fee for massage therapy is $60.00.* This is not billable to insurance, and is my responsibility to pay. Should I have a third "no show", I will be required to pay in advance for any future massage appointment at the time of scheduling. *Insurance companies will not be billed for missed (no show) appointments*.

_____ _____
Printed Name **Date**

_____
Signature

SPINAL & SPORTS CARE CLINIC, P.S.
12905 E. SPRAGUE AVE., SPOKANE VALLEY, WA 99216
(509) 922-0303 FAX (509) 922-0657

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify) _____**

_____

_____

Staff signature **Date**

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PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name_____ Date of Birth: _____

Address _____

Phone Number_____ Chart Number _____

I request and authorize Spinal and Sports Care Clinic PS to use and/or disclose my:

- ☐ **Protected Health Information (PHI)**: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services
- ☐ **Sensitive Protected Health Information (SPHI)**: SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information from my medical record:

Note: Include a detailed description of information to be released including dates.

_____

_____

Release records to:

Name: _____Telephone: _____

Address _____

Purpose(s) for the release:

Note: If the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose.

_____

_____

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.

Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.

- This authorization will expire on ____/___/___ OR when the following event occurs:
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- This authorization CANNOT be used to disclose Psychotherapy Notes.
- Once signed, the Practice will provide me with a copy of this Authorization.
- I understand that the Practice will provide me with a copy of this Authorization once signed by me.

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Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature _____ Date _____

Print Name _____

Relationship to Patient _____

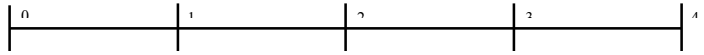
FOR OFFICE USE ONLY	
Verification method:	Date
Verification by:	

Functional Rating Index

For use with **Neck and/or Back Problems Only**

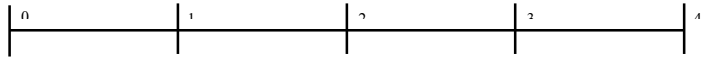
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



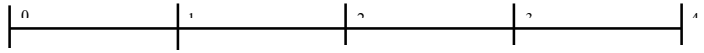
No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

2. Sleeping



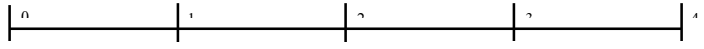
Perfect Sleep | Mildly disturbed sleep | Moderately disturbed sleep | Severe Pain | Worst Possible Pain

3. Personal Care (washing, dressing, etc.)



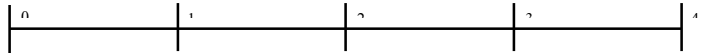
No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance

4. Travel (driving, etc.)



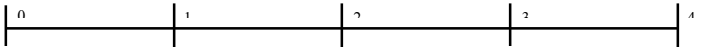
No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips

5. Work



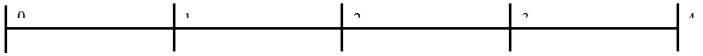
Can do usual work plus unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work

6. Recreation



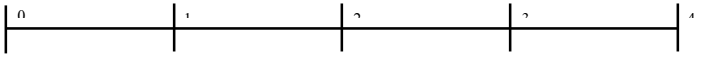
Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities

7. Frequency of pain



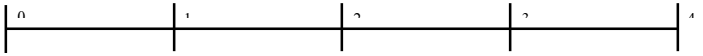
No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day

8. Lifting



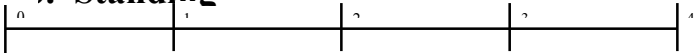
No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight

9. Walking



No pain; any distance | Increased pain after 1 mile | Increased pain after 1/2 mile | Increased pain after 1/4 mile | Increased pain with all walking

10. Standing



No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing

Name (Printed) _____

_____ _____

Signature **Date**

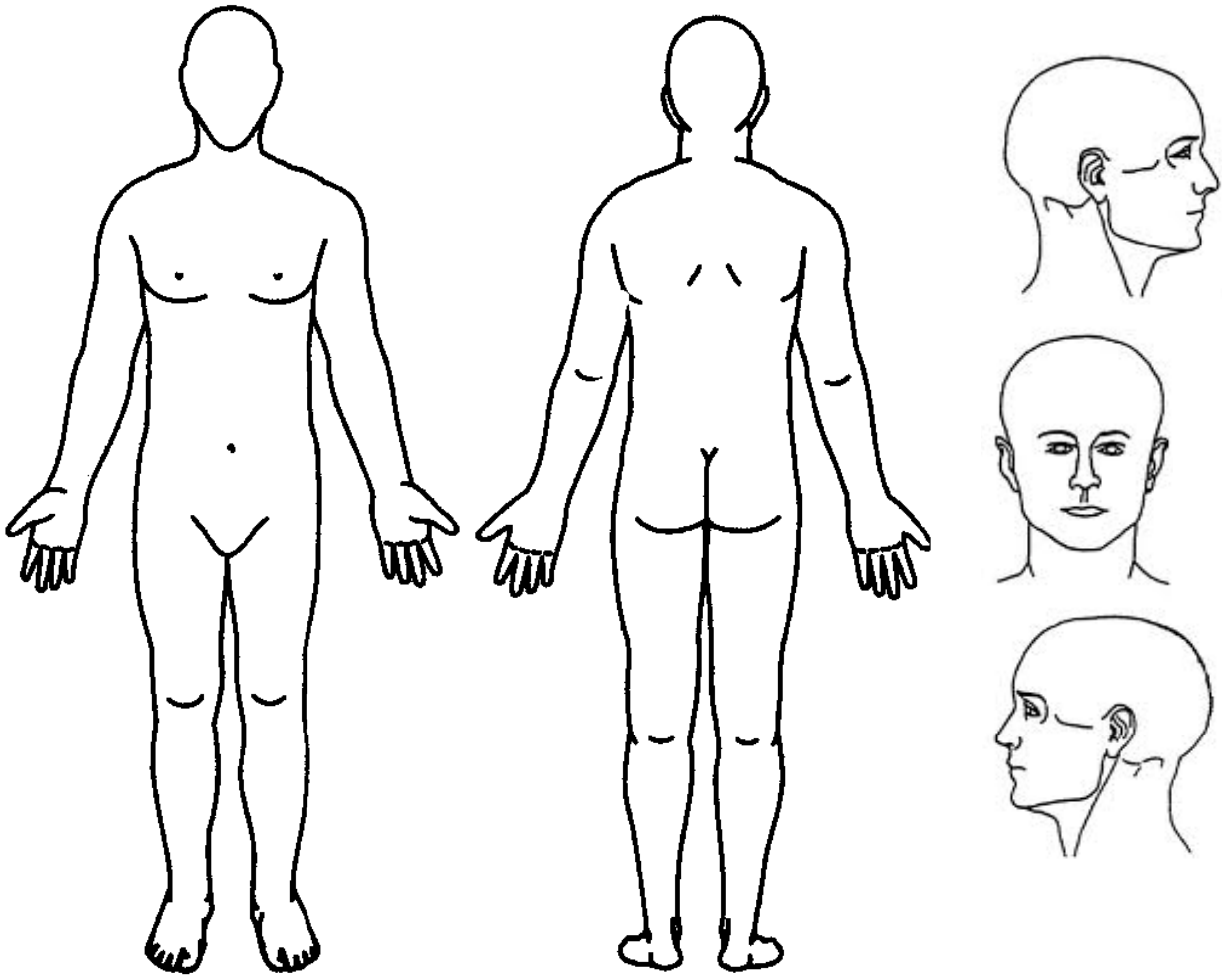
Total Score:

_____

How are you feeling currently?

Please complete this drawing carefully. Mark on the drawing the areas where you feel the described sensation. Use the appropriate symbols and include all involved areas of your body.

NUMBNESS **===** PINS & NEEDLES **OOO** ACHING PAIN **! ! !**
BURNING PAIN **xxx** STABBING PAIN **|||**



Main Complaint is:_____

0	1	2	3	4	5	6	7	8	9	10

NO PAIN LOW MODERATE INTENSE EMERGENCY

Secondary Complaint is:_____

0	1	2	3	4	5	6	7	8	9	10

NO PAIN LOW MODERATE INTENSE EMERGENCY

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