HEALTH HISTORY

Name_____ Phone_____
Address_____
Date of Birth_____ Work Phone_____ Cell Phone_____
Occupation_____ Employer_____
Emergency Contact_____
Physician_____ Referring Physician_____
Physician address/phone_____
Medications (include supplements, herbs, over the counter meds) _____
_____
Are you presently under a doctor's care? Yes _____ No _____ Why?_____
Surgeries (Joint replacements, mastectomy, etc.)_____
_____
Accidents/Injuries_____
_____
Major Illnesses_____
Allergies_____
Do you: Smoke? Yes _____ No _____ How many packs per day?_____
Use Alcohol? Yes _____ No _____ How often?_____
Caffeine? Yes ____ No ____ Type of drink_____ Daily/Weekly_____
Nutrition/Diet _____
Exercise activities_____ How often?_____
If female, are you pregnant? No_____ Yes _____ How many weeks?_____
Hearing aids_____ Glasses/Contacts_____
Have you ever had a massage before? Yes_____ No_____ When?_____
Are you currently being treated by another practitioner? (Chiropractor, Acupuncturist, etc.) ____
If so, who?_____
Areas of pain or discomfort: _____
_____
What makes your condition better? _____
What makes your condition worse?_____
List other pertinent information you think might be useful. _____
_____

It is my choice to receive massage therapy. I am aware of the benefits and risks and give my consent for massage. I understand that the therapies given here are for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

I understand the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I hereby release the massage therapist from any liability for any consequences that may occur as a result of this service. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that payment is due at time of treatment unless arrangements have been made otherwise. I also understand that I am responsible for payment if third party reimbursement is not made.

I agree to give 24 hours notice to cancel any appointments. If less than 24 hours notice is given, I agree that the therapist may charge for the time if unable to fill the appointment.

Signature_____ Date_____

HEALTH HISTORY

Circle any CURRENT or PAST conditions

Headaches
Sinus congestion
Ringing in ears
Loss of smell or taste
Difficulty swallowing
Tightness in the throat
Chronic sore throat
Thyroid dysfunction
Facial flushing or twitching
Loss of memory
Fatigue
Depression
Anxiety
Dizziness, loss of balance
Fainting
Photophobia (light sensitive)
Asthma
Difficulty breathing
Seizures
Epilepsy
Circulatory problems
Chest pain/Heart attack
Heart palpitations
High blood pressure
Low blood pressure
Pacemaker/Defibrillator
Tuberculosis
Hepatitis
Herpes/Shingles
HIV/Aids
Weight changes (>/< 15 lbs)
Anemia
MS (Multiple Sclerosis)
Insomnia (Difficulty sleeping)
Sleep Apnea
Stomach ulcers or pain
Bleeding ulcer
Indigestion
Intestinal gas
Constipation
Bowel/Bladder problems
Kidney problems
Muscle spasms
Muscle tightness or pain
Numbness or tingling
Skin disorders (rash, eczema, etc.)
Night sweats
Excessive perspiration
Liver dysfunction
Diabetes
Cancer (active/remission)
Radiation/Chemotherapy
Painful joints
Arthritis (Osteoarthritis/Rheumatoid)
Osteoporosis
Scoliosis
Pinched nerves
Herniated or bulging discs
Sciatica
Cold feet
Edema (swelling)
Blood clots, phlebitis
Varicose Veins
Aneurysm
Stroke/TIA (paralysis R/L)
Parkinson's

Other conditions not listed_____

How did you find out about our practice? _____

Height_____ Weight_____

How old is your mattress?_____ Is it comfortable to sleep on?_____

Do you fall asleep on: Side_____ Back_____ Stomach_____

Are you wearing: Heel lifts_____ Sole supports_____ Arch supports_____

How many hours a day are you driving? _____

What positions are you in most of the time (sitting/standing/leaning/lifting, etc.)

at work_____ at home_____ elsewhere_____

How do you handle stress?_____

What are your goals for treatment?_____

RN Therapeutics® LLC

693 Reading Ave.
West Reading, PA 19611

NOTICE OF PRIVACY PRACTICES

In accordance with The Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding RN Therapeutics use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by RN Therapeutics.

Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us and we will disclose health information about you to that doctor. For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your medical massage therapist needs to know about, while your medical massage therapist will share all findings with the prescribing doctor.

We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about treatment you are going to receive to determine whether your insurance plan will cover the services. Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for medical massage. Although your health record is the physical property of RN Therapeutics, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions, medical and billing records.

If you believe that health information we have about you is incorrect or incomplete, you may request in writing that we amend your health information for as long as this office keeps the information. Our disclosure of your health information is limited to: this office, the physician who prescribed physical medicine, your insurance company, your attorney, and you. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient, and the patient's health information will be disclosed to the parents or guardian.

If you believe your privacy rights have been violated, you may file a written complain to the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Room 509 F, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.
By signing this form, you hereby acknowledge that RN Therapeutics may release your Protected Health Information to carry out payment and treatment operations.
I have read and understand the Notice of Privacy Practices of RN Therapeutics.

_____ Date_____

Patient/Patient Representative Signature