



## PATIENT INFORMATION

\_\_\_\_\_  
Name

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Street

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
City, State, and Zip

\_\_\_\_\_  
Employer Address

Male  Female

**Contact in case of emergency:**

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Relationship to you

\_\_\_\_\_  
Other Phone (please specify)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email

How would you prefer to be contacted for appointment reminders? email / phone

How did you hear about altTHERA Health? *(if referred, please tell us by whom)*

\_\_\_\_\_

I understand that altTHERA Health has a 24-hour cancellation policy. If I do not cancel my appointment by phone within 24 hours, I will be charged a \$50.00 No Show fee.

\_\_\_\_\_  
Signature and 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.

Balanced Health is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your treatment and services.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your treatment and services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Balanced Health has a more detailed notice on file that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call at any time for a copy of our privacy notices.

### **YOUR RIGHT TO LIMIT USES OR DISCLOSURES**

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment.

### **YOUR RIGHT TO REVOKE YOUR AUTHORIZATION**

You may revoke your consent to us at any time; however, your revocation must in writing. We will not be able to honor revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read this notice and agree to its terms. I am also acknowledging that I have received a copy of this notice.

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Signature of Patient or Authorized Personal Representative

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Date

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Printed Name



**HEALTH HISTORY  
MASSAGE THERAPY**

Patient Name: \_\_\_\_\_

Stressful work/home	Y/N	Osteoporosis	Y/N
Exercise regularly	Y/N	Bruise easily	Y/N
Diabetes	Y/N	Allergies to lotions or oils	Y/N
Arthritis	Y/N	Cardiac or circulatory conditions	Y/N
High blood pressure	Y/N	Numbness or stabbing pains	Y/N
Epilepsy or seizures	Y/N	Sensitive to touch or pressure	Y/N
Joint swelling	Y/N	Injuries in the last 2 years	Y/N
Varicose veins	Y/N	Surgery in the last 5 years	Y/N
Conditions that are contagious	Y/N	Currently pregnant	Y/N

**If you answered yes to any of the above questions, please explain to your Massage Therapist**

Do you have any other medical conditions your Massage Therapist should know about?

\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please circle any painful or tense areas as well as the regions you tend to hold stress:

head/face      neck      shoulders      mid-back      low back      hips

legs/feet      arms/hands      abdomen      other areas: \_\_\_\_\_

What is the amount of tension in your life? 0...1...2...3...4...5...6...7...8...9...10

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 practitioner updated as to any changes in my medical profile. I further understand that massage and/or bodywork 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.

If I experience pain or discomfort during treatment I will immediately inform the practitioner so the pressure may be adjusted to my level of comfort. I understand that it is within my right, as well as the right of the therapist to refuse receiving or facilitating treatment.

I hereby give my consent to receive therapeutic non-sexual massage at Balanced Health and I understand that Balanced Health and its practitioners are not responsible for any personal injury or loss of property.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date