Integrative Health Inc
Experts Providing Healthcare

MASSAGE INTAKE FORM

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

Please complete all areas as completely and accurately as possible. ALL AREAS ARE VALID. All information is private.

Patient Contact Information

Name: ____ Date: ______________

Address:______________________________City:_______________ State:______ Zip:__________

DOB ___/___/_____ Age: ____ Gender:_____________ If minor, name of parent: ________________________

Home Phone: (______)_______________Work#(_____)_______________ Cell #(______)_________________

E-mail address: ________________________ Employer: ______________ Occupation:______________

Married or have a life partner? Yes No Significant other's name: ______________________________

How did you hear of us? Referral: __________________________ Doctor: __________________________

Internet: ______________________ Advertisement: ________________ Other: ____________________

Auto Insurance: If you plan on billing under auto insurance due to a motor vehicle accident or Worker's Comp, please bring this to the receptionist's attention prior to appointment.

Reason for Visit

Are you Pregnant? ☐ Yes ☐ No If yes, how many months? ________________

Are you here because of an injury? ☐ Yes ☐ No if so, please explain: ________________________

____

Primary Purpose of your massage today: ____

____

List any over the counter medications you are currently taking. Please include any herbal supplements, vitamins, etc.

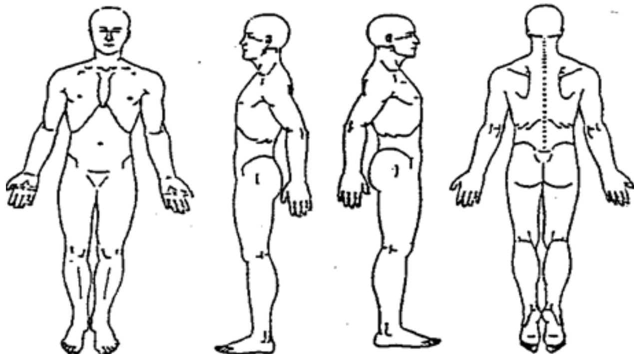
____

____

Do you have any questions, concerns or special needs? ____________________________________

____

Please indicate areas of pain or discomfort:



Description of pain or discomfort

____

____

____

____

____

Medical History (Circle any condition that you have, had or was a significant part of your medical past).

Cardiovascular
Blood clots
Chest Pain
Fainting
Difficulty Breathing
Heart Palpitations
High Blood Pressure
Low Blood Pressure
Irregular Heart Beat
Phlebitis
Tachycardia
Other:____________

Musculoskeletal
Neck/Shoulder Pain
Muscle Pain
Joint Pain
Rib Pain
Limited Range of Motion

Musculoskeletal
Limited Use
Upper Back Pain
Lower Back Pain
Other:____________

AIDS/HIV
Alcoholism
Allergies
Appendicitis
Asthma
Birth Trauma (your own)
Cancer
Chicken Pox
Diabetes
Emphysema
Epilepsy
Goiter
Gout
Heart Disease

Hepatitis
Herpes
Seizures
Multiple Sclerosis
Measles
Mumps
Pacemaker
Pleurisy
Pneumonia
Polio
Rheumatic Fever
Scarlet Fever
Stroke
Thyroid Disorder
Tuberculosis
Typhoid Fever
Ulcers
Venereal Disease
Whooping Cough

Accident History

Date: _____________ Front / Side / Rear Impact traveling _____________ MPH.

Any treatment? ____

Date: _____________ Front / Side / Rear Impact traveling _____________ MPH.

Any treatment? ____

Date: _____________ Front / Side / Rear Impact traveling _____________ MPH.

Any treatment? ____

Surgical History

Year	Type/Area
_________	______________________________
_________	______________________________
_________	______________________________
_________	______________________________

Current Medications

Name	Purpose
_______________________	_________________________
_______________________	_________________________
_______________________	_________________________
_______________________	_________________________

Traumas (fractures, stitches, etc.)

Year	Type/Area
_________	______________________________
_________	______________________________
_________	______________________________

Supplements/Herbs

Name	Purpose
_______________________	_________________________
_______________________	_________________________
_______________________	_________________________

5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

_________ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_________ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_________ (initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

_________ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_________ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

_________ (initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

_________ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

____

Your Printed Name

____ ___________

Signature Date

5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

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Your Printed Name

____ _____________

Signature Date