snovalley
MASSAGE THERAPY

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## WELCOME

Welcome to SnoValley Wellness Therapy. We are honored you have chosen us to guide you through your rehabilitation process. We understand filling out paperwork can be difficult. We have made a concerted effort to minimize the amount of paperwork required, while also making sure we have all the information we need to provide you with the highest quality of service.

## PATIENT INFORMATION

Patient Name: (*First*) _____ (*Last*) _____ (*M.I.*)____

Address: _____ City, State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M / F

Status: Single Married Divorced Widowed Other:_____

Home #:(_____) _____ Cell #:(_____) _____ Work #:(_____) _____
Please note whether we have permission to leave a detailed message on your answering machine if we are unable to reach you in person. Home: Yes No Cell: Yes No Work: Yes No

Email Address: _____ *SnoValley Wellness Therapy will not share, sell or trade your information*

Automated Appointment Reminder preference: Email SMS/Text on Cell Voice Call on Cell/Home/Work

Diagnosis or Chief complaint(s): _____

Date of Injury/Onset: _____ Did you have surgery? Yes No If yes, when? _____

Referring Doctor: _____ Clinic/Hospital: _____

Patient's Employer: _____ Patient's Spouse or Parent: _____

**How did you hear about us?** (Please check one):

☐ Doctor ☐ Friend/Relative ☐ Return Patient ☐ Phone Book ☐ Internet Search
☐ Clinic Sign ☐ Insurance List ☐ Charity Event ☐ Seminar ☐ Newspaper
☐ Community Event ☐ Other: _____

**In case of emergency, please contact**: (List a friend or relative that can be reached during office hours)

Name: _____ Phone #: (_____) _____ Relationship: _____

**If patient is under the age of 18, name of parent/guardian completing and signing documentation:**

Name: _____ DOB: _____ Relationship: _____

## CONSENT TO RECEIVE TREATMENT

By signing below, I agree to the following:

- I voluntarily give SnoValley Wellness Therapy my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that therapy involves manual techniques that require appropriate physical contact by the health care provider and staff.

**Signed:** _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

## CANCELLATION AND BROKEN APPOINTMENT POLICY

We would like you to be aware of our cancellation and broken appointment policy. **Any appointments cancelled or broken within 24 hours of their scheduled time will be assessed a $120 fee.**

If a cancellation is unavoidable we do ask that you give us as much notice as possible so we may offer that appointment to another patient.

Successful therapy is dependent on a strong working relationship between the patient and the physical therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments prescribed by their therapist. **It is very important to attend each appointment when it is scheduled.**

By signing below, you acknowledge that you have read our policy and understand your commitment to a successful outcome is essential. The cancellation fee is not covered by insurance and will be collected at the time of your next visit or billed directly to you as an out of pocket expense.

**Signed:** _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

## RECEIPT OF PRIVACY PRACTICES

By signing below, you acknowledge receipt of the Notice of Privacy Practices of SnoValley Wellness Therapy. You are also authorizing SnoValley Wellness Therapy to release your records to your insurance company and physician. Please understand your records are held in strict confidence and we will not release them to any unauthorized person. Our Notice of Privacy Practices provides further information about how we may use and disclose your protected health information. We encourage you to read it in full.

**Signed:** _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

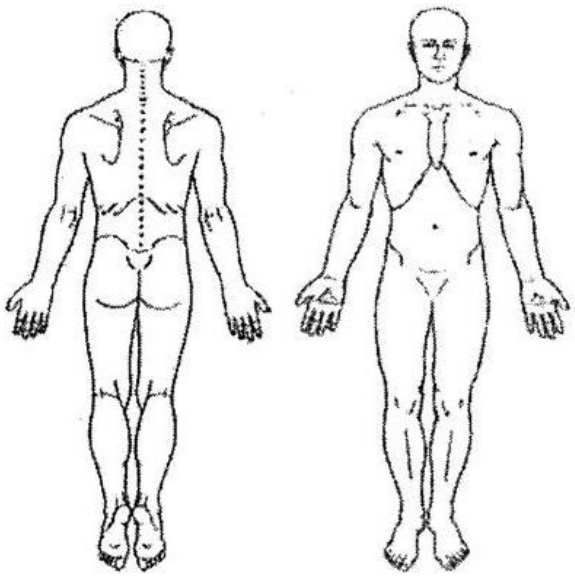
I authorize SnoValley Wellness Therapy to discuss my medical and/or billing information with the above named person(s).

**Signed:** _____ **Date:** _____
(Parent/Guardian's signature if child is under 18 years old)

## HISTORY OF PRESENT CONDITION

What are you seeing us for? _____
_____
_____

Please indicate where you have pain/symptoms:



When did this issue begin? _____

Describe the history of this problem (i.e. how did it occur?): _____
_____
_____

Was the onset of your symptoms gradual or sudden?
☐ gradual ☐ sudden

Overall, are your symptoms:
☐ improving ☐ getting worse ☐ no change

Have you had similar symptoms in the past?
☐ Yes ☐ No

How would you describe your symptoms? (select all that apply)
☐ sharp ☐ throbbing
☐ dull ☐ shooting
☐ numbness ☐ aching
☐ tingling ☐ burning
☐ other :
_____

Please indicate the average intensity of your symptoms (0-lowest, 10-highest):

0 5 10

As you go through your day, do your symptoms:
☐ increase ☐ decrease ☐ stay the same

Does pain ever wake you up at night?
☐ Yes ☐ No

What aggravates your symptoms?
☐ sitting ☐ standing
☐ lying down ☐ bending forward
☐ walking/running ☐ sleeping
☐ up/down stairs ☐ coughing/sneezing
☐ reaching overhead ☐ turning/twisting body
☐ lifting objects ☐ sustained movements
☐ playing a sport ☐ stress
☐ repetitive activities ☐ other _____

Does anything relieve your symptoms? Please explain:
_____
_____

Have you had any previous treatment or tests for this condition? (select all that apply)
☐ physical therapy ☐ x-ray
☐ massage therapy ☐ MRI
☐ chiropractic care ☐ CT scan
☐ traction ☐ EMG
☐ bracing/taping ☐ bone scan
☐ hospitalization ☐ acupuncture
☐ bed rest ☐ casting
☐ exercise ☐ medication/injection
☐ home health care ☐ other _____

Please list any current medications, including over the counter and supplements: _____
_____
_____
_____
_____

## HISTORY OF PRESENT CONDITION continued

Since your symptoms began, have you had any of the following?

- ☐ bowel or bladder issues
- ☐ weakness
- ☐ dizziness or fainting
- ☐ fever/chills/sweats
- ☐ significant weight change
- ☐ hearing or vision problems
- ☐ numbness or tingling
- ☐ difficulty swallowing
- ☐ pain at night
- ☐ numbness in the anal or genital area
- ☐ vague feeling of bodily discomfort
- ☐ NONE

Are you currently able to perform all of your regular work/home duties? Yes No

If no, please list activities that you are not able to do: _____

_____

In general, would you say your overall health is:

Poor — Excellent

Your exercise/activity level is:

Inactive — Very Active

If active, please describe: _____

_____

Do you smoke? ☐ Yes ☐ No

_____ packs/day _____ packs/week

Do you drink alcohol? ☐ Yes ☐ No

_____ drinks/day _____ drinks/week

Occupation:_____

Does your job include any of the following?

☐ sitting ☐ standing ☐ lifting

What is your current living situation? (select all that apply)

- ☐ live alone
- ☐ live with family/friends
- ☐ home/apartment
- ☐ single level/no stairs
- ☐ multiple levels/stairs
- ☐ have caregiver
- ☐ retirement community
- ☐ assisted living
- ☐ other : _____

Do you currently have or have you had a history of any of the following? (select all that apply)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cancer/Tumor
- ☐ IBD (Crohn's, UC)
- ☐ Anemia
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Nausea/Vomiting
- ☐ Cardiac arrhythmias
- ☐ Pacemaker
- ☐ Blood clots
- ☐ Peripheral Vascular Disease
- ☐ Bruising easily
- ☐ Neurological conditions
- ☐ Sleep disorder
- ☐ Seizures/Epilepsy
- ☐ Thyroid problems
- ☐ Pulmonary conditions
- ☐ Multiple Sclerosis
- ☐ Kidney problems
- ☐ Parkinson's disease
- ☐ Fractures
- ☐ Joint replacement
- ☐ Arthritis/Swollen joints
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Dizziness/Vertigo
- ☐ Loss of balance/Falls
- ☐ Shortness of breath
- ☐ Infectious disease
- ☐ Use of steroids/inhalants
- ☐ Currently pregnant
- ☐ Depression
- ☐ Chemical dependency
- ☐ Sensitivity to heat/ice
- ☐ Allergy to adhesive/ tape/lotions
- ☐ Angina
- ☐ Coronary Artery Disease

Please list any PREVIOUS surgeries:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

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# Consent Form - Massage Therapy

I understand that the massage given to me by Richard A. Green, PT, DPT, CHT, LMT is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or for other specific reasons as might be noted below).

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

If at any point during the massage I am uncomfortable or uneasy with the procedures being administered, and/or if I experience pain, I understand it is my responsibility to immediately inform the massage therapist, so that the massage can be terminated or the strokes and pressure can be adjusted to a level of comfort.

Prior to massage treatment, remove all jewelry. Pull long hair back with a clip.

Please provide feedback as to pressure (deeper or lighter) and discuss painful or ticklish areas of your body.

Feel free to ask questions about the procedures. Your massage therapy provider is well trained, ethical, and professional, and will be happy to make you feel well informed and comfortable.

Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment. Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.

All massage treatments, information and records will be kept confidential and securely stored for use only by my massage therapist.

Written consent must be given by me prior to any disclosure or sharing of my personal and clinical information with any third party.

Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist. Fees will be maintained per the schedule.

**Cancellation of any appointment must be received at least 24 hours in advance; otherwise a $120 appointment fee is due.** A No Show is charged the same fee.

Fees for treatment are due prior to departure on the day of the treatment. Cash, credit cards or health savings cards are all acceptable forms of payment.

Client Signature_____ Date_____