

ZYGMONT CHIROPRACTIC CENTER
1700 S. Lamar Blvd., Suite 301, Austin, Texas, 78704
Telephone: (512) 442-7400 Fax: (512) 442-7405

MASSAGE INTAKE FORM

Personal Information

Today's Date _____

Name: _____ Sex: Male Female
Last First M.I.

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____
Home Work Mobile

E-mail Address: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you to the massage therapist? _____

Goals for Massage Therapy Session

What can we do to help you today? _____

When did this problem begin? _____ Has this ever happened before? _____

Symptoms developed from: injury illness gradual onset unknown causes

Symptoms come and go are constant are getting worse

Symptoms have persisted for: hours one day weeks months years

Symptoms are *better* in: morning noon night

Symptoms are *worse* in: morning noon night

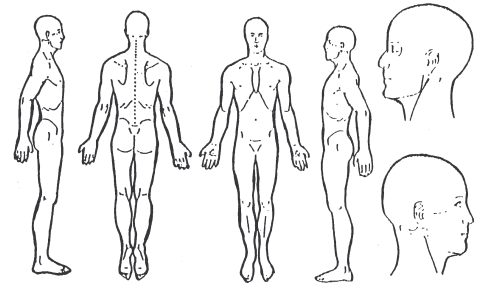
Symptoms do not change with the time of day: yes no

What activities make the condition *worse*? _____

What activities make the condition *better*? _____

Remarks and additional information: _____

Are you pregnant? yes no



Past Medical History

Indicate any significant illness you have (please include date):

Cancer _____ Diabetes _____ Hepatitis _____ Seizures _____

Stroke _____ HIV/AIDS _____ Other _____

High blood pressure _____ Pacemaker _____

List any accidents or surgeries you have had (include date): _____

List all medications you are now taking (include prescription drugs, over-the-counter medications, herbs, and nutritional supplements): _____

Please check items you use or have: coffee/tea caffeinated soft drinks sugar tobacco
 alcohol recreational drugs water aspirin, Tylenol, Ibuprofen

Have you ever received massage before? _____

REQUEST AND CONSENT

I consent to receive therapy services known as Therapeutic Massage, and I authorize the Registered Massage Therapist to perform these services. Therapeutic massage treatment is not intended as a substitute for medical treatment or diagnosis. The massage therapist reserves the right to terminate treatment at his or her discretion.

I understand that the breast area and genitals will be avoided. Other areas I wish to be avoided are:

I understand that draping will be used. I further understand that if I become uncomfortable for any reason during the treatment I may ask the therapist to cease the massage treatment and the massage session will be terminated.

I have read and understand the above and agree to these terms.

Client signature _____ Date _____

Printed name _____

Financial Responsibility

I understand that I am financially responsible for all charges whether or not reimbursable by insurance.

Responsible Party Signature Relationship Date

Privacy Acknowledgement Form

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Zygmont Chiropractic’s “Notice of Privacy Practices” has been provided to me. I understand I have a right to review Zygmont Chiropractic’s 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 Zygmont Chiropractic. The Notice of Privacy Practices for Zygmont Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and Zygmont Chiropractic’s duties with respect to my protected health information.

Zygmont Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative Description of Personal Representative’s Authority

Marcy Salazar
Privacy Officer