2376 Main Street Suite 3
Ferndale, WA 98248

LondonHealthCenter
community natural medicine

(360) 384-2900

MASSAGE INITIAL EXAM REVIEW

Patient Name:_____ Date:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX AND PROVIDING ANY NECESSARY CLARIFICATIONS.

Yes	No	
☐	☐	1. Have you ever had a professional massage? What other ways do you relieve stress?
☐	☐	2. Do you exercise regularly or participate in any sports? If yes, what kind and how often?
☐	☐	3. Are you currently under the care of a physician or other health care provider for a specific condition? If so, please explain:
☐	☐	4. Do you take any medications (include aspirin and ibu)? If yes please list all medications, dose and use:
☐	☐	5. Are you pregnant? If so, due date:
☐	☐	6. Do you wear contact lenses? Hard or soft (please circle)
☐	☐	7. Do you wear dentures?
☐	☐	8. Do you wear hearing aids?
☐	☐	9. Do you have any needs that require special attention? If yes, please specify:
☐	☐	10. Do you want specific results from your massage? If yes, please describe:

IF YOU HAVE HAD OR HAVE ANY OF THE CONDITIONS LISTED BELOW, PLEASE CHECK THE BOX TO THE LEFT AND PROVIDE ANY NECESSARY CLARIFICATIONS.

☐ Skin Problems	☐ High Blood Pressure	☐ Circulatory issues	☐ Anxiety/Depression
☐ Allergies	☐ Low Blood Pressure	☐ Diabetes	☐ Infectious Disease
☐ Cancer	☐ Varicose Veins	☐ Osteoarthritis	☐ Sleep issues
☐ Heart issues	☐ Blood clots	☐ Rheumatoid Arthritis	☐ Spinal Problems

Do you have any other medical conditions that I should be aware of before you receive massage?
If yes, please explain: _____

I Understand that massage practitioners do not diagnose illness, disease, or other physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my know medical conditions and take it upon myself to keep the massage practitioner update on my physical health.

Signature:_____ **Date:**_____

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Patient Name:_____ Date:_____

Date	Previous History (Injuries, falls, surgeries, illness)	Treatment(s):

Name 3 problem areas: (for example; headache, tension, pain) then rate the intensity on a scale of mild, moderate or severe. How long has this occurred?

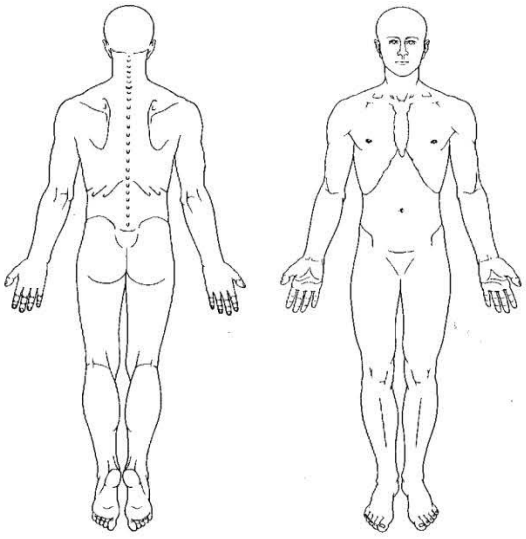
_____

_____

_____

PAIN RATING

Please indicate on the drawing the location of your pain or discomfort.



Please rate the severity of your complaint(s) **over the last 24 hrs** (10 = worst pain):

At its **worst**: 0 1 2 3 4 5 6 7 8 9 10

At its **best**: 0 1 2 3 4 5 6 7 8 9 10

Currently: 0 1 2 3 4 5 6 7 8 9 10

What makes the symptom *better*? (mark all that apply):	**What makes the symptom *worse*?** (mark all that apply):		**Describe the symptom:** (mark all that apply):
❑ rest ❑ ice ❑ heat ❑ stretching ❑ exercise ❑ massage ❑ pain medication ❑ nothing	❑ bending head ❑ bending at the waist ❑ twisting at waist ❑ getting up from sitting ❑ any movement ❑ walking ❑ nothing	❑ turning head ❑ standing ❑ sitting ❑ lifting ❑ driving ❑ running	❑ sharp ❑ dull ❑ achy ❑ burning ❑ throbbing ❑ stabbing ❑ deep ❑ shooting

Please fill out both sides of this form

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Thank you for selecting London Health Center. To help us meet your health care needs. please fill out this form completely in ink. If you have any questions or need assistance, we will be happy to help you.

Personal Information

Legal Name: _____ Today's Date:_____

Wishes to be called: _____ Date of birth: _____

□ Married □ Significant Other □ Single □ Divorced □ Widowed □ Separated

Gender Identity: □ Female □ Male □ Neither □ Both □ Other

Gender Assigned at birth: □ Female □ Male □ Choose not to disclose

Contact Information Please check preferred phone number

□ Home Phone: _____ □ Work Phone:_____

□ Cell Phone:_____ Email: _____

Automated text/email okay? □*Yes* □*No* *Is is okay to leave a message*? □Yes □No

Address: _____

City, State, Zip: _____

Employer: _____ Occupation:_____

In case of emergency, who should we contact? Name: _____

Relationship_____Work # _____Home # _____

Insurance Information We will make a photocopy of your insurance card

Primary Insurance_____ Subscriber's Name_____ DOB_____

Secondary Insurance_____ Subscriber's Name_____ DOB_____

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center, Inc. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize London Health Center, Inc. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
I understand that charts will be shared if I am seeing more than one provider at London Health Center and information may be discussed between providers in this clinic.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X_____ _____
Signature of patient or parent if minor Date

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NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

London Health Center, Inc. (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of you protected health information ("PHI"). In other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions**: To request access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications**: To receive correspondence of confidential information by alternate means or location. To do this, please make your request in writing.
- **Access**: To inspect or receive copies of your PHI. To do this, please make your request in writing.
- Accounting: To recieve an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please make your request in writing.
- This notice: to get updates or reissue of this notice at your request.
- Complaints: To complain to our office or the US Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: To obtain more information on or have your questions about your rights answered: you may contact the Practice's Privacy Office, Dr. Angela London at London Health Center, Inc. 2376 Main Street, Ferndale, WA 98248.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____	_____	_____
Patient Signature	Date	Print Patient Name