Brookview WELLNESS
HOLISTIC CHIROPRACTIC CARE
Tori Tucker, LMBT #15100
1501 Lakestone Village, LN Ste 105, Fuquay Varina, NC 27526
www.brookviewwellness.com P : 919-577-2225 F : 919-577-2226

Name:_____ Phone:_____ DOB: _____

Address: _____ City/State/Zip:_____

Email:_____ Occupation:_____

Emergency Contact: _____ Phone:_____

Have you ever had a professional massage before? Yes____No____

Are you pregnant? ____Yes** ___ No_ **If yes, we do not provide prenatal massage as we are not yet certified.

Do you have any known allergies? If yes, please list_____

_____

Are you currently under a medical doctor's care? If yes, please explain_____

_____

Do you take any prescription medication? If yes, please list_____

_____

PLEASE MARK IF YOU HAD/HAVE ANY OF THE FOLLOWING CONDITIONS:

Current Fever, Cold, or Flu***	Shingles/Impetigo***	Ringworm/Fungal Skin Infections***
RA, Lupus or Gout Flare Up***	Congestive Heart Failure***	Bleeding disorder***
Pneumonia***	Hepatitis***	Thrombosis, Embolism or Phlebitis***

***** Total Contraindication for Massage Therapy - Massage will not be performed*****

TIA / Stroke**	Respiratory disorder**	Epilepsy**
Active Cancer**	Heart condition**	Aortic Aneurysm**
Multiple Sclerosis**	Cirrhosis**	Renal Failure**
Myasthenia Gravis**	Normal Pressure Hydrocephalus**	

**** For your safety we require a letter from your medical doctor releasing you for massage therapy****

History of Cancer	HIV/AIDS	Surgery - Pins, Rods, Screws, Plates
Osteoporosis	Artificial joint	Fracture within last year
Skin disorder	Diabetes	Edema

Please note, if you arrive sick or with a cold, your appointment will be rescheduled and payment will be taken and used for a deposit for your next massage therapy visit. Having a massage while sick will worsen your condition, please call or go online to reschedule your appointment within 24 hours.

Reason for visit? What areas of your body are you experiencing pain, tension, stiffness, or other discomfort?

Body parts that may be treated include face, neck, scalp, shoulders, arms, hands, back, glutes, hip flexors, legs and feet. Oftentimes, to get to the root cause of dysfunction massage may take place on the following muscle groups: glute, abdominal, chest, inguinal/adductor, however we do not engage in massage of breast tissue or genitalia. Please initial that you are aware that the above areas may be massaged.

_____Initials

Our massage therapist utilizes only conservative draping during your session. As a medical office your therapist will also wear non-latex, powderless nitrile gloves for the safety of both parties. Please initial that you understand, this policy.

_____Initials

I will respect the time of my massage therapist and other patients. I agree to come to my scheduled appointments promptly, barring any unforeseen emergency. I understand that if I cancel later than 24 hours I will be responsible for **HALF** of the cost of the appointment. If I **NO SHOW/NO CALL**, I agree to pay the **FULL** price of the appointment.

_____ Initials

Do you have any other medical issues about your health history that wasn't covered above such as past surgeries or injuries that I should be aware of before you receive massage therapy? If yes, please describe._____
_____

Bruising and soreness is possible with Massage Therapy, as adhesions are released from the tissues. This doesn't always occur it depends on which techniques are used. Please initial that you understand this possible outcome.
_____ Initials_____
_____

How did you hear about us? _____

_____

****Please read the following, then sign and date below****

I,_____(print name) understand that the massage therapy I receive is provided for the purpose of relief of muscular tension or relaxation. Conservative draping will be used during the massage therapy session. If I experience any pain or discomfort during the massage therapy session, I will immediately inform the massage therapist, so the pressure and/or strokes may be adjusted. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical physician or chiropractor for any physical or mental ailment that I am aware of. I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose, prescribe, or treat any mental or physical illness, and that nothing said during the session should be construed as such. I understand that massage therapy should not be performed under certain medical conditions*******. I affirm that I have stated all my known medical conditions and answered the above questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that should my medical profile change under certain medical conditions, the massage therapist may require a Doctor's note from my physician before massage therapy sessions continue.

Client Signature: _____Date: _____

Therapist Signature: _____Date: _____

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Dr. Brooke M. Breitbach, DC
Dr.Shelby L. Woodbury, DC
Tori Tucker, LMBT #15100
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NOTICE OF PRIVACY FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

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 shall honor that 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. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to request restricted use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may be unable to treat if the consent is not obtained.

_____ _____

Printed Name of Patient **Printed** Clinic Representative

_____ _____

Signature of Patient **Signature** of Clinic Representative
(or parent/legal guardian, as applicable)

_____ _____

Date: Date: