SIRIN

Bassi Jones Building 7834 SE 32nd Street, Ste. 202 Mercer Island, WA 98040
info@sirinmassage.com • sirinmassage.com
Phone: 425.417.7775

PERSONAL INFORMATION

Today's Date _____

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Occupation _____

Phone: Home _____ Work _____ Cell _____

Date of Birth _____ Age _____ Gender: ☐ F ☐ M

How did you hear about us? _____

Injury Treatment? ☐ Yes ☐ No Date of Injury _____ Please Describe _____

_____

Referral? ☐ Yes ☐ No Referrer _____ Phone # _____

Preferred method for reminder calls: ☐ Email ☐ Text (SMS) _____

HEALTH HISTORY

List all incidents that you can remember that may or may not be contributing to your present condition. Please include approximate dates.

Accidents _____

_____

_____

_____

Injuries _____

_____

_____

Surgeries _____

_____

_____

_____

Sports _____

_____

_____

CURRENT SYMPTOMS

What makes your current symptoms better? _____

What makes your current symptoms worse? _____

Any range of motion restrictions? _____

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms: ☐ Shooting ☐ Throbbing ☐ Dull ☐ Sharp/Stabbing

☐ Burning ☐ Numbness ☐ Soreness ☐ Tingling

Can you perform your daily HOME activities: ☐ without pain ☐ with pain

Explain: _____

Can you perform your daily WORK activities: ☐ without pain ☐ with pain

Explain: _____

How is the quality of your sleep? _____ Hours of sleep lost _____

List current medications: _____

_____

Why are you here today? _____

_____

LOCATION OF PAIN

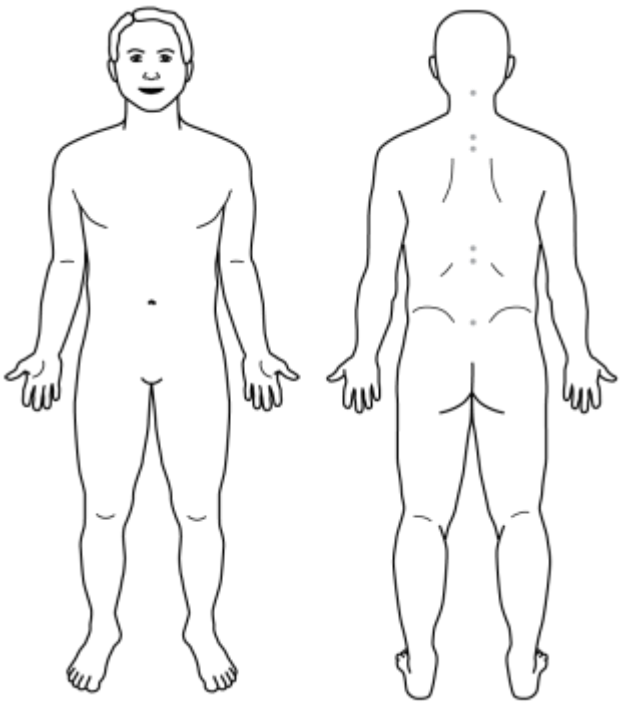
Please circle the site of your pain(s) on illustration to right.
(Rate the severity of pain, using a scale of 1-10)

1-3: Pain does not limit activities in any way

4-6: Pain requires a modification of some activities

7-9: Pain prevents some activities

10: Excruciating, disabled or bedridden



Have you ever experienced any of the following?

Please write 'C' for Current, 'P' for Past, 'S' for Sometimes in the blank.

_____ Abdominal Problems
_____ Allergies
_____ Arthritis
_____ Asthma
_____ Ankle Problems
_____ Anemia
_____ Anxiety
_____ Back Pain (Upper, Mid, Low)
_____ Bed Wetting
_____ Bone Spurs
_____ Breast Lumps
_____ Breast Pain
_____ Breast Implants
_____ Bronchitis
_____ Bunions
_____ Bursitis
_____ Calf Problems
_____ Cancer
_____ Carpal Tunnel Syndrome
_____ Chest Pain
_____ Colic
_____ Constipation
_____ Diarrhea
_____ Depression
_____ Diabetes
_____ Diaphragm Pain
_____ Digestive Problems
_____ Dizziness
_____ Ear Problems
_____ Edema
_____ Fatigue (Chronic)
_____ Fibromyalgia
_____ Fractures (Old/New)
_____ Gallbladder Problems
_____ Hamstring Problems
_____ Headaches/Migraines
_____ Heart Problems
_____ Heartburn
_____ Hernia
_____ High Blood Pressure
_____ Hip Pain
_____ Hip Replacement
_____ HIV/AIDS
_____ Incontinence
_____ Infertility
_____ Jaw Problem
_____ Joint Replacement
_____ Kidney Problems
_____ Knee Problems
_____ Liver Problems
_____ Lung Problems
_____ Multiple Sclerosis
_____ Neck Pain
_____ Numbness/Tingling
_____ Orthodontia
_____ Osteoporosis
_____ Parkinson's Disease
_____ Pelvic Problems
_____ Plantar Fasciitis
_____ Pregnant
_____ Prostate Problems
_____ Rheumatoid Arthritis
_____ Rib Problems
_____ Sacral Problems
_____ Sciatica
_____ Scoliosis
_____ Shin Splints
_____ Shoulder Problems
_____ Sinus Problems
_____ Sleep Problems
_____ Sprains/Strains
_____ Swollen Feet/Legs
_____ Tennis or Golf Elbow
_____ Tinnitus
_____ TMJ Problem
_____ Whiplash
_____ Wrist Pain

Other _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

In accordance with the Health Information Privacy and Accountability Act (HIPAA), all health care providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding this office's use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by SIRIN.

Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed massage will disclose your health information to us and we will disclose health information about you to that doctor. For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your massage therapist needs to know about, while your massage therapist will share all findings with the prescribing doctor.

We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about treatment you are going to receive to determine whether your plan will cover it.

Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of massage and the liability of payment for massage.

Although your health record is the physical property of SIRIN, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions and medical and billing records.

If you believe that health information we have about you is incorrect or incomplete, you may request in writing that we amend your health information for as long as this office keeps the information.

Our disclosure of your health information is limited to: this office, the physician who prescribed physical medicine, your insurance company, your attorney, and you. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient, and the patient's health information will be disclosed to the parents or guardian.

I recognize that electronic communication, such as email, online scheduling, voice mail and texting cannot guarantee privacy. SIRIN will take reasonable steps to maintain your privacy but you understand that electronic communication and cell phone texting has the possibility of being hacked. If you engage in electronic communication you are aware your privacy could be violated and are willing to bear the risk. You will not hold SIRIN liable for any breach in privacy for electronic communication or texting if you use these methods.

If you believe your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Your signature below indicates that SIRIN may release your Protected Health Information to carry out payment and treatment operations.

I have been given and read the HIPAA information for SIRIN.

Client Name (printed) _____ Date _____

Client Signature _____

PLEASE READ AND SIGN THE FOLLOWING

I have completed this form to the best of my knowledge and will inform Joy Dunning of any change in my physical health. I understand a massage therapist cannot diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have. I understand that massage therapy is a therapeutic health aide and is non-sexual.

Cancellation Policy

I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized. I agree to give a 24-hour notice for a scheduled session that I cannot keep. I am aware that I will be charged the full fee for any missed sessions of for sessions that I do not give a 24-hour notice to cancel or reschedule.

Client Signature _____ Date _____