

WELCOME TO WHOLE HEALTH CENTER

CONTACT INFORMATION

First Name: _____ Last Name: _____

Address: _____

City, State, ZIP: _____

Patient Sex: Male Female **Date of Birth:** _____

Telephone: Home _____ Cell _____ Work _____

Do we have your permission to send appointment reminders, and clinic updates to your email address?

Yes _____ No _____ We will not sell or give your email to any other agency.

Email Address: _____

Emergency Contact: Name _____

Telephone _____ Relationship _____

How did you hear about us?

Friend or Family (name) _____

Whole Foods Website Internet Other: _____

Please be advised, we do NOT bill health insurance for massage or naturopathy services outside of car accident and workman's compensation claims. If you have any questions, please ask the front desk staff.

Health Insurance: YES NO

Ins Co: _____ Subscriber Name: _____

Subscriber ID#: _____ Group #: _____ Subscriber DOB: _____

Subscriber SSN: _____ Patient SSN: _____

MISSION STATEMENT

Whole Health Center provides information, education, and access to complementary health services for people seeking wellness. Whole Health Center connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: _____ Date: _____

Whole Health Center Massage Therapy

Name: _____ Date: _____ Occupation: _____

Have you had a massage before? _____ Did you enjoy your last massage? _____

Purpose of this massage: _____

Are you pregnant? _____ If yes, how many months? _____

What questions or concerns or special needs do you have? _____

Would you like a FREE Chiropractic Examination and Consultation (Adjustment Not Included)? YES NO

Medical History: (Please Check all that apply)

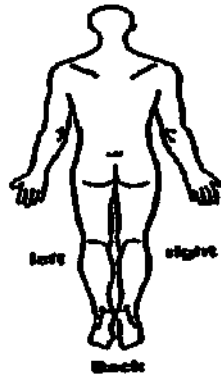
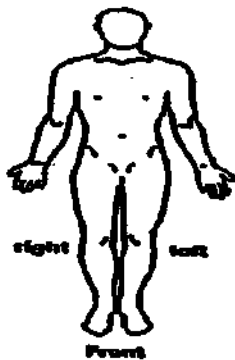
- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pace Maker | _____ |
| <input type="checkbox"/> Heart Disease | | |

Surgical History:

1. _____ Year: _____ 2. _____ Year: _____

Medications: _____

Please mark ALL areas of pain or discomfort:



If you require medical records for an insurance claim, please make this request to your practitioner upon your initial visit.

Date of Request: _____ Initials: _____

Given the strict adherence to massage therapy being a non-sexual service, clients may remove all or part of their clothing (depending on their comfort level) to improve the therapeutic value of the massage. If you have any questions or concerns about this topic, please discuss these concerns with your massage therapist. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral may be required prior to service being provided.

I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified specialist for any suspected ailments. I understand that nothing said during the course of a session should be construed as diagnosis or prescription. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree to keep the practitioner updated as to any changes and understand that there shall be no liability on the practitioner's part should I forget to do so. I also understand that all information provided on this form or given verbally while in session is strictly confidential other than as required for insurance billing purposes or required by law. Any other release of this information cannot be granted without written consent.

By signing below, I acknowledge that I fully understand and agree to the above information.

Signature: _____ Date: _____
(Signature of patient or legal guardian)

Print Name: _____