PEAK PERFORMANCE
CHIROPRACTIC & SPORTS MEDICINE

Massage Therapy New Patient

Contact Information

Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Sex: □M / □F Marital Status □S □M □D □W

Address: _____ Zip: _____

Contact Number: _____□C □H □W Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number: _____

Past History *List any Falls, Injuries, Auto Accidents, Fractures, Dislocations, Surgeries, Hospitalizations, Allergies*

_____

_____

_____

Current History (*Check if you have any of the following symptoms or system/ organ dysfunction)*

□ Heart □Cancer □Depression □Tuberculosis □Seizures □Stroke □Thyroid problems □Drugs/Alcohol □Liver □Kidney □Spleen □High blood pressure □Diabetes □Arthritis □Colon □Stomach □Nerve □Disc Herniation □Blood Clots □Embolism □Bleeding Problems □ Easily Bruised □ Skin □Rash □Asthma □Lung Disease □HIV+ □Fever □Nausea □Vomiting □Dizziness □Headache □Unexplained Weight Loss □Change in bowel/ bladder frequency □Concussion □Weakness in arms / legs ◘Other_____

Current Complaint

Complaint: □No Complain_____

What caused this? _____

Onset Date? _____

□Sharp □Dull □Achy □Burning

□Mild □Moderate □Severe

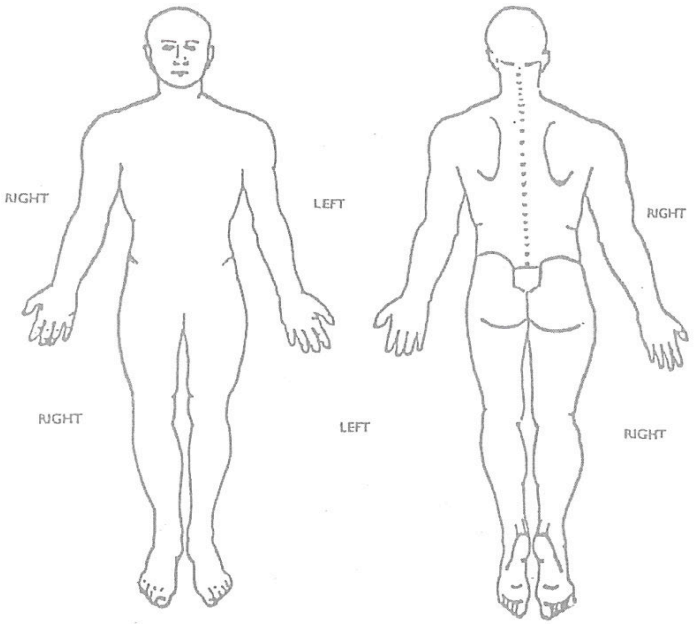
□Constant □Intermittent □With Activity

Radiates to:_____

What makes pain better? _____

What aggravates pain? _____

Mark location of pains on diagram



0 1 2 3 4 5 6 7 8 9 10

(No Pain) (Very Severe)

12485 Monument Rd Ste 16 Jacksonville, FL 32225 p:(904)351-6596 f:(904)212-0484 JoyHenryDC@gmail.com

PEAK PERFORMANCE
CHIRORPACTIC & SPORTS MEDICINE

Informed Consent I herby give Performance Chiropractic & Sports Medicine, LLC's licensed Massage Therapists, Dr. Joy Henry, and her assistants to render Massage and Manual Therapies. Manual Therapies may include Massage, Instrument Assisted Soft Tissue Mobilization, Myofascial Release, Neuromuscular Therapy, and Trigger Point Release. These therapies help to decrease muscle spasm, tightness, soreness, and trigger points**. Massage means the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation**. I understand Massage is not intended for the treatment or cure of a specific disease or illness, but to help maintain optimal efficiency of the body. I understand that there are alternatives to Massage Therapy. Patients will be referred to the appropriate health care provider when Massage Therapy is not suitable for the patient's condition, or the condition warrants co-management in conjunction with other members of the patient's health care team. These alternatives include chiropractic adjustments, neuromuscular therapy, acupuncture, holistic medicine, and allopathic medicine. I understand the benefits of Massage Therapy and how it can positively affect my condition. I have had the opportunity to discuss the nature of my conditions with the therapist and understand why and how care and manual therapies may help me. I will ask questions when applicable, or if I do not understand, at anytime. I understand that all information is confident and only utilized for my medical benefit. **Acknowledgement of Receipt of Notice of Privacy Practice** I acknowledge that Peak Performance Chiropractic & Sports Medicine, LLC has provided me with a digital copy of its Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. This can also be found at <http://jaxsportschiro.com/forms> This acknowledgment means only that I have received the notice, and in no way affects the care I receive. Peak Performance Chiropractic & Sports Medicine, LLC will attempt to contact me via the provided phone number, but it is my responsibility to notify the office should I choose not to be contacted for appointment reminders. Peak Performance Chiropractic & Sports Medicine, LLC may contact me for purposes of providing information regarding treatment alternatives, services, or goods, and that it is my responsibility to notify the office should I choose not to be contacted regarding treatment alternatives, services or goods. Peak Performance Chiropractic & Sports Medicine, LLC utilizes a color pain diagram as my treatment sign-in for each visit. Adjustments will be conducted on field, in a locker room, or in a semi private room where visibility is permitted though room windows. It is your right to request closure of the window curtains or relocation of treatment off field to increase privacy. I understand that forms will be place in my chart and maintained for 6 years. I understand that, under certain circumstances, medically necessary information, regarding my health and ability to participate in practice and games will be discussed with coaches. **Release of medical Information to Insurance** Carrier I give permission to Peak Performance Chiropractic & Sports Medicine, LLC to release all medical information files in relation to my history and treatments to my insurance carrier in order to facilitate processing of insurance claims. **Assignment of Insurance** I assign the payments of benefits due to me under my insurance policy with my carrier, and direct my insurance carrier to pay for all services rendered directly to Peak Performance Chiropractic & Sports Medicine, LLC. **Liability Waiver for Gym Use** Bailey's Gym is available for exercise demonstrations and therapeutic exercise ONLY while under the direct supervision of a Peak Performance Chiropractic & Sports Medicine, LLC staff members. I understand and acknowledge that any use of Bailey's Gym presents risk including, but not limited to, the following: accident, injury, illness, or even death. I assume all risk of injuries associated with the use of Bailey's Gym and understand that Peak Performance Chiropractic & Sports Medicine, LLC and Bailey's Gym, Inc. are not liable for any injury endured. I understand that I have the right to refuse use or demonstration of exercises and that all participation is voluntary. I understand that I am required to sign an additional waiver with Bailey's Gym prior to entry, including entry for use of the restroom.

***(if applicable)* CONSENT TO TREAT A MINOR**: I hereby authorize Peak Performance Chiropractic & Sports Medicine, LLC's licensed Massage Therapists, Dr. Joy Henry, and her assistants to administer the necessary Massage and Manual Therapies, as they deem necessary, and without my presence when necessary to the above named patient.

Relationship: _____ Phone Number: _____

_____ **(initial) Release of Medical Information to Personal Trainers (if applicable)**

I give permission to Dr. Joy Henry and Peak Performance Chiropractic Sports Medicine to discuss medically necessary information, regarding my health, with my personal trainer, in order to help cater my work out plan.

_____ _____ _____

Print Name (Parent or Guardian) Signature (Parent or Guardian) Date

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