Brostrom Physical Therapy

Spine and Extremity Institute of South Lyon, LLC

Massage Therapy Form Set
Patient Information

First Name:_____ **MI**:_____ **Last Name**:_____

*** Phone**: (h)_____(c)_____ (w)_____

*From time to time, it may be necessary for the Brostrom PT staff to leave a detailed message on your phone pertaining to appointment times or treatment information. Please check phone numbers where you authorize the Brostrom PT staff to leave messages containing the specified content:

- **Appointment times** ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- **Treatment information** ☐ Home Phone ☐ Cell Phone ☐ Work Phone

☐ I prefer that the Brostrom PT staff does not leave detailed messages on any of my phones.

Please initial in the corresponding boxes to indicate your consent to receive electronic appointment reminders:

☐ Mobile reminders ☐ Email reminders ☐ Decline electronic reminders

Address:_____

City: _____ **Zip**:_____

Email Address: _____

Sex: M F **Date of Birth**:_____ **Marital Status**: m s d w

Student Status: ☐ Full-time ☐ Part-time ☐ Not a Student

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

Primary Care Physician (PCP): _____

Emergency Contact with Phone Number. Name:_____

Phone #:_____ Relationship:_____

☐ Appointment times ☐ Health insurance coverage ☐ Treatment information

How did you hear about Yvonne, Danielle, and/or Brostrom Physical Therapy?

_____

By signing, I authorize that the above information is accurate and complete to the best of my knowledge. I also understand this form will act as an authorization of release of information to the people and phones specified above. I also hereby authorize my consent to Brostrom Physical Therapy to send appointment reminders electronically via text message to my mobile phone or by e-mail. I understand that this service is offered free of charge, but standard messaging rates from my mobile carrier may apply depending on my plan. **I can withdraw my consent to electronic communications by calling Brostrom Physical Therapy at (248) 446-0155.**

_____ _____

Signature/Signature of Parent or Legal Guardian **Date**

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Health Questionnaire

Name:_____ Date:_____

Profession:_____

Massage Experience: Have you received a professional massage before? ☐ Yes ☐ No

If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc.)?

_____

Please explain massage experience/history: _____

What are your goals for treatment?_____

Current Medications: Please provide a list of all current medications in the table below. If you are not taking any medications currently, simply check the box below.

☐ I am not currently taking any medications

Medication Name (including prescription, over-the-counter, herbal, vitamin, and dietary supplements)	**Dosage**	**Frequency**	**Route Taken** (for example: oral, injection, inhaler, etc.)

Surgeries, Recent Hospitalizations, and Pertinent Past Medical History:

Please list all surgeries (accompanied with the date of the surgery), recent hospitalizations, and pertinent past medical history:

Surgery(ies):	***Date:***

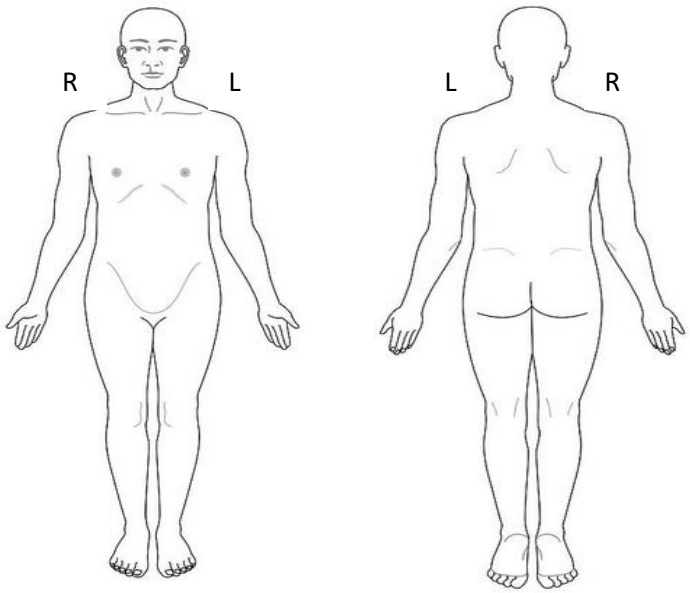
Recent Hospitalization(s):	***Date:***

Pertinent Past Medical History ***(e.g. an accident resulting in an injury):***

_____

_____

Please circle areas of discomfort or tension:



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Health Questionnaire

Musculoskeletal:

- ☐ Bone or joint disease
- ☐ Tendonitis/Bursitis
- ☐ Arthritis/Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal problems_____
- ☐ Migraines/headaches
- ☐ Osteoporosis

Circulatory:

- ☐ Heart condition
- ☐ Phlebitis/Varicose veins
- ☐ Blood clots
- ☐ High/low blood pressure
- ☐ Lymphedema_____
- ☐ Thrombosis/Embolism

Reproductive:

- ☐ Pregnant, stage _____
- ☐ Ovarian/Menstrual Problems
- ☐ Prostate

Respiratory:

- ☐ Breathing difficult/Asthma
- ☐ Emphysema
- ☐ Allergies (□ seasonal □ food □ meds □ lotions/scent) (list:_____)
- ☐ Sinus problems

Nervous System:

- ☐ Shingles
- ☐ Numbness or tingling_____
- ☐ Pinched nerve_____
- ☐ Chronic pain_____
- ☐ Paralysis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Fibromyalgia

Skin:

- ☐ Allergies (□ latex/adhesives) (list:_____)
- ☐ Rashes
- ☐ Athlete's Foot

Digestive:

- ☐ Irritable Bowel Syndrome
- ☐ Bladder/Kidney Ailment
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers

Psychological:

- ☐ Anxiety/Stress Syndrome
- ☐ Depression

Other:

- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Drug/Alcohol/Tobacco Use
- ☐ Contact Lenses
- ☐ Dentures
- ☐ Hearing Aids
- ☐ Any other medical condition(s) not listed: _____

_____

_____

Patient Policies

Initial:	**COVID-19 Symptom Verification:** I understand and will comply with BPT's request to cancel and/or reschedule my appointment(s) if I develop a fever (100.4°F), uncontrolled cough, or atypical new onset of shortness of breath, or at least two of the following not explained by a known physical condition: loss of taste or smell, muscle aches, sore throat, severe headache, diarrhea, vomiting, or abdominal pain.
Initial:	**Modesty Agreement:** I understand that, to protect my privacy, it is required that full covering underwear be worn at minimum. I further understand that bras are optional based on my comfort.
Initial:	**Client Agreement:** It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.
Initial:	**Assignment of Benefits:** I am responsible for all charges for all service(s) provided unless covered by the following: Auto Comp/Work Comp/_____
Initial:	**Release of Medical Records:** I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of medical correspondence and/or processing my claims.
Initial:	**Contract for Care:** I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.
Initial:	**Cancellation and No-Show Policy:** I understand I will be assessed a charge of **$50.00 per occurrence** for a no-show appointment (if I forget or consciously choose to forgo my appointment without notice). A patient is considered to have a no-show appointment if they are not present 15 or more minutes beyond their scheduled appointment time, without notice. I further understand that I will be assessed a charge of **$25.00 per occurrence** for a late cancellation appointment (if I call to cancel less than 8 hours prior to my scheduled appointment). (**Note:** If you are ill, we kindly ask that you provide as much notice as possible and reschedule your appointment.)

By signing, I authorize that the above information is accurate and complete to the best of my knowledge.

_____ _____

Signature/Signature of Parent or Legal Guardian **Date**