Natural Health Practices
4904 Clyde Morris Blvd. Suite A | Port Orange, FL 32129 | 386-307-8207

HEALTH QUESTIONNAIRE FOR NEW MASSAGE CLIENTS

PLEASE PRINT CLEARLY

Full Name:	Today's Date:
Mailing Address:	Apt #:
City and State:	Zip:
Email Address:	Phone:
Preferred primary method of contact (circle one): Email Phone Call Text Message	Whom may we thank for referring you to us?

Occupation:		Employer:		
Date of Birth:	Age:	Sex: M / F	Height:	Weight:
Your overall health (circle one): Excellent Good Fair Poor		Do you (circle all that apply): Use Tobacco Products Drink Alcohol Drink Tap Water		
Please list and prioritize your current health concerns (stress, pain, stiffness, numbness/tingling, swelling, etc.):				
Current medications:		Current nutritional supplements:		
List any major illnesses, accidents, or injuries with approximate dates:		List any surgeries or operations (include out-patient or "routine" procedures) with approximate dates:		
Are you currently under the care of a physician or another healthcare professional? (If yes, please give names and dates of most recent visits):				

Are you pregnant? Yes No	Have you had a professional massage before? Yes No
Massage pressure you prefer (circle one): Light Medium Firm I don't know	What specific areas would you like us to focus on?
Is there anything else you would like to tell us so we can better serve you?	

CONSENT TO TREATMENT, OFFICE POLICIES, AND USE OF PROTECTED HEALTH INFORMATION

Massage Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Office Policies

We believe that you alone are responsible for your health choices and not your insurance company. Insurance companies and their representatives have become increasingly selective in denying reimbursement for services while also increasing deductibles and copays. Knowing this, many doctors across the country are choosing to forego insurance. Our office operates as a private pay practice, which allows us to offer affordable care to patients without interference or influence from a third party company.

If you are unable to make a scheduled appointment, we respectfully request that you cancel a minimum of 24 hours in advance, so your appointment time can become available for another patient. By cancelling at least 24 hours in advance, you can avoid a missed appointment fee, which will be deducted from prepaid treatment plans or paid upon next office visit. Naturally, our desire is to make appointment time available to other patients – not to collect missed appointment fees.

Your signature below constitutes your acknowledgement that: (1) You have read and agreed to the above treatment and office policies and; (2) The procedures and possible alternate means of therapy have been adequately explained to you by your doctor; (3) You acknowledge that you are responsible for payment at time of service and that there is no guarantee your insurance company will reimburse you for exams, services, or supplements; (4) You agree not to publish misrepresentative or libelous statements about Natural Health Practices Inc., Dr. Seidenberg, or employees on any social media or public internet website.

Consent for Use and Disclosure of Protected Health Information

In addition to the above treatment and office policies, your signature constitutes your acknowledgement that: (1) You have read a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request; (2) You understand that this office reserves the right to revise its Notice of Privacy Practices at any time and it will be available to patients upon request; (3) You consent to the use of your protected health information in a manner consistent with State and Federal Law, this office's Notice of Privacy Practices, and the HIPAA Compliance Manual.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship: _____