Convergent Therapies, PLLC

Massage & Movement

www.convergenttherapies.com
(253) 858-4845

How did you hear about us? ______________________

Health History Questionnaire

Date: ____________

Patient Name (Last, First, MI)	Date of Birth	Phone ( )
Patient's Address (No. Street)	Email Address	
City, State	Zip Code	Occupation
Emergency Contact	Relation to patient	Phone ( )

Would you like us to bill your insurance? If so, please complete the following:

Insured's Name (Last, First, M.I.)	Date of Birth	Phone ( )
Insured's Address (No. Street)	Insurance Carrier/Plan Name	
City State	Zip Code	Relation to patient

What is your main complaint today? ____

When did this problem begin? (Please be specific)

____

____

What do you think caused it? Is the cause still present?

____

____

Have you been given a diagnosis for this problem? If so, what? ______________________

What treatments have you tried already? What were the results?

____

____

How severe is your problem right now? (Please mark the scale below. 1 = minimal; 10 = severe/excruciating)

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What's the most severe level you have endured within the last week? (Please mark the scale below)

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Are you being seen for a work injury? ❑ Yes ❑ No

Are you being seen for a motor vehicle injury? ❑ Yes ❑ No

Are we billing your insurance company for services rendered? ❑ Yes ❑ No
If yes, then please complete the following:

Referring Physician	Phone ( )	Fax ( )
Primary Care Physician	Phone ( )	Fax ( )
Injury occurred: ❑ On the Job ❑ Motor Vehicle Accident ❑ Other ______________________		
Diagnosis: ____ Date of Injury/Onset _____________		

Please answer the following questions as best you can:

Are you currently seeing a doctor for any reason? ❑ Yes ❑ No If yes, please explain:

Are you allergic to anything? ❑ Yes ❑ No If yes, please explain:

Do you have any skin conditions (i.e. eczema, rashes, etc.)? ❑ Yes ❑ No If yes, please explain:

Do you have or have you had any circulatory problems? ❑ Yes ❑ No If yes, please explain:
i.e., high blood pressure, low blood pressure, DVT, clotting disorders, etc.

Are you currently taking any medications? ❑ Yes ❑ No If yes, list all medications:

Have you had any surgery in the last 5 years? ❑ Yes ❑ No If yes, please explain:

How often do you receive massage?

What are your specific goals for today's massage session?

Are you currently experiencing any of the following conditions?

❑ Flu or Cold ❑ Inflammation ❑ Fever ❑ Pain/Tenderness ❑ Numbness/tingling
❑ Swelling ❑ Contagious Disease ❑ Infection ❑ Stiffness

Cancellation Policy
Please understand that your time commitment begins the moment you reserve a massage appointment. In order to be fair to everyone, please consider your schedule carefully and don't commit to a time that you feel may be questionable. There are times when cancellation is, of course, necessary. If you need to cancel or reschedule your appointment, please do so more than 24 hours before your appointment time. Failure to do so will result in a charge for the full amount of the time allotted. For insurance patients, the cash pay amount will be charged.

Guarantee of Payment
For insurance claims, patient agrees to pay the balance of the billed amount if the insurance company does not pay or only partially pays the billed amount. The only exception is if the therapist is a contracted provider with that particular insurance company. In that case, the patient will be billed only the deductible, copay, or co-insurance if applicable.

Agreement for Care
I agree to allow the massage therapist to perform therapeutic massage on me. I understand that massage therapists do not diagnose illness, prescribe medications or manipulate bony structures. I have alerted my therapist to any conditions that I have and have disclosed all medications (herbal or pharmaceutical) that I am currently taking. I further agree to update my therapist to any changes in my mental, emotional, or physical health. I understand and have had explained to me the procedure, benefits, and contraindications for massage and the side effects which may occur as a result of massage. The information provided here will not be distributed to other parties unless specified by the patient with a signed consent form.

Notice of Privacy Practices - Acknowledgement
We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Convergent Therapies office.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices and consent and agree to the policies stated above.

______________________________________ ______________________________
Signature of patient or legally authorized individual Date Time

______________________________________ ______________________________
Printed name (if signed on behalf of the patient) Relationship
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update: 10/19/08