

**A R C A D E**  
C H I R O P R A C T I C

Dr. Andy Ingram  
401 Euclid Ave. STE 140  
Cleveland, OH 44114  
(216) 522-0300  
www.arcadechiro.com

## MASSAGE NEW PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  Female  Male

Phone Number(s) \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Marital Status:     Single                       Married                       Minor                       Widowed

Divorced                       Separated                       Partnered for \_\_\_\_ years

Spouse/Partner's Name \_\_\_\_\_

## Emergency Contact

Emergency Contact's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_

## Health History

Injuries/Surgeries	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
	_____	_____
	_____	_____

# Patient Condition

Reason for visit: \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  yes  no  unknown

Rate the severity of your pain on a scale of 1 (least) to 10 (most severe) \_\_\_\_\_

Type(s) of pain:  sharp  dull  throbbing  numbness  aching  swelling  
 shooting  burning  tingling  cramps  stiffness  other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_ Is it:  constant  intermittent

Does it interfere with your:  work  sleep  daily routine  recreation

Which activities are painful to perform?

sitting  standing  walking  bending  lying down  other \_\_\_\_\_

What treatment(s) have you already received for your condition?  medication  surgery

physical therapy  chiropractic services  none  other \_\_\_\_\_

Name and phone of previous doctor(s) \_\_\_\_\_

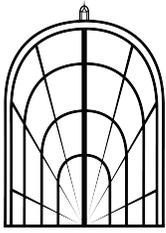
Place a check to indicate if you have had any of the following:

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergy Shots <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fractures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herniated Disk <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pinched Nerve <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Prosthesis <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors/Growths <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Other(s) _____ _____
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Are you pregnant?  yes (Due Date \_\_\_\_\_)  no  breastfeeding

## How did you hear about us?

Google  Social Media  Reference \_\_\_\_\_  Other \_\_\_\_\_



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## CONSENT TO TREATMENT

### AUTHORIZATION FOR TREATMENT AT ARCADE CHIROPRACTIC

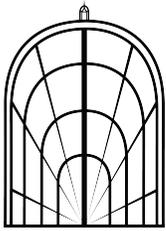
- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort.
- I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that today's services are not a substitute for medical care and that my therapist is not qualified to diagnose, prescribe, or treat physical/mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition and that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.

**By signing this release, I waive and release my therapist from any liability, past, present, and future, relating to massage therapy and bodywork.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship if not patient: \_\_\_\_\_



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## HIPAA RELEASE

### AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 and required by April 14, 2003, Arcade Chiropractic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use of and/or disclosure of protected health information described below.

I hereby consent to this practice to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice. This consent includes contact of and discussion with other healthcare professionals for my care and treatment.

I hereby authorize the use and/or disclosure(s) of the following protected health information that pertains to me: my medical records and diagnoses, including but not limited to all lab/x-ray reports, progress reports, and other information.

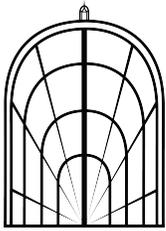
I understand that I have the right to:

- Refuse to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- To inspect and obtain a copy of any protected health information disclosed relating to this authorization.
- Receive a signed copy of this authorization.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship if not patient: \_\_\_\_\_



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## CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Andy Ingram to perform diagnostic tests and render chiropractic adjustments, NAET treatments, and/or other treatment to my child \_\_\_\_\_.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

IF APPLICABLE: Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_