

H.I.P.P.A. FORM

ACKNOWLEDGMENT AND CONSENT

I understand that Tim Haster, LMT, (referred to below as "Practitioner") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the Practitioner, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this Practitioner may **use and disclose** my health information within the practice of Studio Blue LLC, in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers within Studio Blue LLC. for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how this Practitioner will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Studio Blue LLC and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of this Practitioner's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this Practitioner is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that a copy of the Notice of Privacy Practices is available to me should I request it.

By: _____ Date: _____ (Patient)

-OR-

By: _____ Date: _____ (Patient representative)
Description of Representative's Authority: _____

Rehabilitative Massage, LLC
Timothy Haster, LMT #10525

Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated by Timothy Haster, LMT. I understand that massage therapists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed M.D. or D.O. is an important choice that Timothy Haster, LMT strongly recommends.

Therapeutic Massage/Reflexology/Myofascial Release/Trigger Point Therapy/PNF/Neuromuscular Re-education: I understand that I may also be given massage therapy in the form of Therapeutic Massage, Reflexology, Myofascial Release, Trigger Point Therapy, PNF and/or Neuromuscular Re-education as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I have been made aware that certain adverse side effects may result from the treatment. These could include, but are not limited to: muscle soreness or aching and the possible aggravation of symptoms existing prior to the treatment. I understand that I may stop this therapy if it is uncomfortable and that I am responsible for informing Timothy Haster, LMT at once if I experience discomfort.

I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

Signature _____ Date: _____

Printed Name _____

Patient Auto Injury/Medical History Form

Name: _____ Date: _____
Age: _____ Date of Birth: ____/____/____ M ____ F Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Referred by: _____
Home Phone #: _____ Work or cell #: _____
SS#: _____ Driver's License #: _____
Spouse's Name: _____
Insurance Company: _____ Name of Agent: _____
Insurance Company Phone #: _____ Agent's Phone #: _____
Claim Number: _____
Address of Insurance Company: _____
Have you retained an attorney? _____ Name, Address, Phone # of Attorney: _____

Vehicles Involved:

Your Vehicle - Year _____ Make _____ Model _____ Other Vehicle Year _____ Make _____ Model _____
Accident Type: Rear ended Head-on Broad-sided Your Speed _____ Other Vehicle Speed _____
Damage to Your Vehicle: \$ _____ Other Vehicle Damage: \$ _____
Date of accident: ____/____/____

Describe Accident: _____

Specifics of Accident (Mark each that applies to the accident):

- Job or Work Related injury () Yes
Your were the Driver Passenger
Sitting Front seat Back seat
 Seat belted No seatbelt
Impending Collision Aware Unaware
 Braced Not braced
Head Did Strike Object Not strike Object
 Broken Glass
Did you experience Shock Loss of Consciousness
 Flash of Light Seen Upon Impact
Air bag Deployed

State your Emotions and Physical State *Immediately Following*
the accident:

Immediately Following the Accident

- Ambulance – Paramedics Called
 Treated at Scene
 Transported to Hospital by Ambulance
 Went to Hospital on their Own
 Diagnostics Performed at Hospital
 Treatment at Hospital
 Medication Prescribed
 Follow-up Recommended

Other Doctors Seen:

- Orthopedist Neurologist
 Psychiatrist Physical Therapist
 Massage Therapist Chiropractor

The Road was:

The Weather Conditions were:

- Dry Sunny Light rain
 Wet Cloudy Heavy rain
 Icy Foggy Snowing
 Snowy
Time of Day: Dawn Day Dusk Night Unknown

Patient Auto Injury/Medical History Form

Symptomatology (Pain Characteristics for Major Area of Complaint):

The pain started _____

The pain is made better by _____ and
worse by _____

The pain has the following qualities:

There is There is not radiation into _____

There is There is not referred pain into _____

There is There is not parasthesia (tingling/numbness) into: _____

The pain is located _____
The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

Daily Activities

Pain Rating

How many days out of an average week do you have pain? _____ On a scale of 1- 10 rate your pain.
How much time out of an average day are you in pain? _____

No Pain											Severe Pain
0	1	2	3	4	5	6	7	8	9	10	

What are the worst times of day for the pain? _____ Describe the overall severity of the pain
What are the best times of day for the pain? _____

- Mild Nuisance
- Mild to moderate but can live with it
- Moderate, having trouble coping with it
- Severe, it is ruining my quality of life

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Progression
How is your pain compared to when the pain episode first started?

- Much improved
- A little worse
- Somewhat improved
- Much worse
- No Change

What do you do to relieve the pain? _____

Patient Auto Injury/Medical History Form

Please mark each that apply to your Daily Activities

- Stays at home most of the time due to the problem.
- Changes position frequently to try and get comfortable.
- Walks more slowly than usual because of the problem.
- Does not do jobs around the house because of the problem.
- Has to use handrails to get up stairs, etc.
- Has to lie down and rest frequently due to the problem.
- Has to hold onto something to sit or stand from a chair.
- Has to get other people to do things for you.
- Has difficulty getting dressed due to the problem.
- Can only stand for short periods due to the problem.
- Has difficulty bending or kneeling due to the problem.
- Has difficulty turning over in bed due to the problem.
- Has a loss of appetite due to the problem.
- Can only walk short distances because of the problem.
- Has difficulty sleeping because of the problem.
- Has to get dressed with someone's help.
- Has to sit most of the day because of the problem.
- Has more irritable because of the problem.
- Has difficulty climbing stairs.
- Stays in bed most of the day because of the problem.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before?

How often do you have to stop activities and sit or lie down to control your symptoms?

- Several times a day Never
- Occasionally All Day
- Approximately once per day

Social History

- Single Smoker
- Married Non-Smoker
- Divorced Drinks Alcohol
- Number of Children: _____ Does not drink Alcohol
- Takes Drugs Does not take Drugs

List your Hobbies & Exercise Activities

Occupational History

Your Employer _____

What is your current job satisfaction:

- Very Satisfied
- Dissatisfied
- Very Dissatisfied

Are your Job Duties Physically demanding for you? Yes No

Have you had any disability time? Yes No

If you are currently working which are you performing?

- Regular Duties
- Limited – Light Duties

Your highest level of education attained? _____

Patient Auto Injury/Medical History Form

Medical History

List the Physicians and other practitioners your have seen for _____

List the Medications you are currently taking: _____
your problem.

List the treatments you have had for your problem.

- Hot packs / Ultrasound
- Massage
- Electrical Stimulation
- TENS Unit
- Body Mechanics Training
- Strengthening Exercises
- Aerobics
- Gravity Inversion – Traction
- Bed Rest
- Chiropractic
- Osteopathy
- Biofeedback
- Trigger Point Injections
- Epidural Injections
- Back Brace
- Acupuncture
- Naturopathy

List the types of Diagnostic Testing that has been performed for this problem.

- X-rays
- CT Scan
- Myelogram
- MRI Scan
- Discogram
- Bone Scan
- EMG

List Past Surgeries: None _____

List previous back, neck and musculoskeletal problems you have had.

List Past Hospitalizations: None _____

Medical History

Mark if you have had any of the following symptoms in the past 5 years.

- Unexplained fevers
- Night sweats
- Weight loss of 10 lbs or more
- Loss of appetite
- Excessive fatigue
- Problems with depression
- Difficulty sleeping
- Unusual stress at work
- Unusual stress at home
- Easy bruising
- Excessive bleeding
- Lumps in neck, armpit or groin
- Chest pain or tightness
- Persistent or unusual cough
- Trouble breathing with exercise
- Trouble breathing lying flat
- Coughing up blood
- Swollen ankles
- Stomach pain
- Change in bowel habits
- Persistent diarrhea
- Excessive constipation
- Dark black stools
- Blood in stools
- Pain-burning when urinating
- Difficulty urinating – start / stop
- Blood in urine
- Need to urinate more at night
- Morning stiffness
- Persistent eye redness
- Muscle tenderness
- Dry eyes or mouth
- Skin rashes
- Joint pain or swelling

Females – Mark if have the following:

- Vaginal bleeding other than period
- Pap smear within last two years
- Painful menstrual periods
- Back pain with menstrual periods
- Other menstrual problems

Do you have any current problem with:

- anxiety
- depression
- irritability

Do you have a home exercise program that you follow on a regular basis?

- Yes
- No

Name: _____ Date: _____