

## **Instructions: How to fill out the proper paperwork**

First of all I want to congratulate you in making the choice of change. I know paperwork can be daunting .I have tried to simplify this process. If at anytime during this process, you become confused or have questions, feel free to either email or call my office. I will personally address your questions [tim@rehab-massage.com](mailto:tim@rehab-massage.com) 503-224-5073.

1. All clients need to fill out the pages entitled *HIPPA Form Acknowledgment and Consent; Treatment Consent Form*.
2. Those of you, who have been in an auto accident, please fill out the form titled: *Patient Auto Injury/Medical History Form* (4 pages).
3. Those of you, who have not been in an accident, please fill out the forms titled *Patient History* (2 pages)

# 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: _____<br>(Patient) |
|------------------------------------|

-OR-

|   |
|---|
| By: _____ Date: _____<br>(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       | 10          |
| 1       | 9           |
| 2       | 8           |
| 3       | 7           |
| 4       | 6           |
| 5       | 5           |
| 6       | 4           |
| 7       | 3           |
| 8       | 2           |
| 9       | 1           |

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: \_\_\_\_\_

# Rehabilitative Massage, LLC

## Timothy P. Haster, L.M.T. #10525

### PATIENT HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Referred By: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Email address: \_\_\_\_\_

#### PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

Major Complaint: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Date Began: \_\_\_\_\_

Have you lost work days: Yes ( ) No ( ) How many? \_\_\_\_\_

Have you had this similar condition before? Yes ( ) No ( ) When? \_\_\_\_\_

Was the injury related to: work accident ( ) auto accident ( )

#### PAST (0) OR PRESENT (X) CONDITIONS:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Fractured Bones                 | <input type="checkbox"/> Learning Disability                          | <input type="checkbox"/> Wheezing                          |
| <input type="checkbox"/> Auto Accidents                  | <input type="checkbox"/> Mistake sidedness (R. from L.)               | <input type="checkbox"/> Heart Problems                    |
| <input type="checkbox"/> (a) _____ 0-1 years ago         | <input type="checkbox"/> Stutter                                      | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> (b) _____ 1-5 years ago         | <input type="checkbox"/> Dyslexia                                     | <input type="checkbox"/> High or low blood pressure        |
| <input type="checkbox"/> (c) _____ More than 5 years ago | <input type="checkbox"/> Mood Changes                                 | <input type="checkbox"/> Varicose Veins                    |
| <input type="checkbox"/> Other Accidents / Falls         | <input type="checkbox"/> Lose Temper Easily                           | <input type="checkbox"/> Liver Trouble                     |
| <input type="checkbox"/> Knocked Unconscious             | <input type="checkbox"/> Headache                                     | <input type="checkbox"/> Gall Bladder Trouble              |
| <input type="checkbox"/> Back Curvature                  | <input type="checkbox"/> Neck pain or stiff R.L.                      | <input type="checkbox"/> Digestive Problems                |
| <input type="checkbox"/> Mental or Emotional Disorders   | <input type="checkbox"/> Numbness, tingling, or pain in arms          | <input type="checkbox"/> Excessive Gas                     |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> hands, fingers R.L.                          | <input type="checkbox"/> Belching/bloating after meals     |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Jaw Pain or Click (TMJ) R.L.                 | <input type="checkbox"/> Heartburn                         |
| <input type="checkbox"/> Swollen or Painful Joints       | <input type="checkbox"/> Head seems too heavy                         | <input type="checkbox"/> Ulcers                            |
| <input type="checkbox"/> Convulsions / Epilepsy          | <input type="checkbox"/> Head & Shoulders feel tired                  | <input type="checkbox"/> Diarrhea / Constipation           |
| <input type="checkbox"/> Skin Problems                   | <input type="checkbox"/> Difficulty in excessive (standing            | <input type="checkbox"/> Colon Trouble                     |
| <input type="checkbox"/> Itching                         | <input type="checkbox"/> walking, sitting, riding, bending,           | <input type="checkbox"/> Hemorrhoids                       |
| <input type="checkbox"/> Bruise Easily                   | <input type="checkbox"/> lifting, twisting, household duties)         | <input type="checkbox"/> Prostate problems                 |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Shoulder pain R.L.                           | <input type="checkbox"/> Impotence                         |
| <input type="checkbox"/> Frequent Colds/Flus             | <input type="checkbox"/> Dizziness                                    | <input type="checkbox"/> Kidney Stones                     |
| <input type="checkbox"/> Nervousness                     | <input type="checkbox"/> Ringing in ears R.L.                         | <input type="checkbox"/> Kidney Trouble                    |
| <input type="checkbox"/> Tension                         | <input type="checkbox"/> Hearing Loss R.L.                            | <input type="checkbox"/> Frequent Urination                |
| <input type="checkbox"/> Depressed                       | <input type="checkbox"/> Fainting                                     | <input type="checkbox"/> Discharge                         |
| <input type="checkbox"/> Irritable                       | <input type="checkbox"/> Loss of balance                              | <input type="checkbox"/> Menstrual problems / PMS          |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Low back pain or stiffness R.L.              | <input type="checkbox"/> Menopausal problems               |
| <input type="checkbox"/> Excess Sweating                 | <input type="checkbox"/> Upper back pain or stiffness R.L.            | <input type="checkbox"/> Breast lumps, soreness, discharge |
| <input type="checkbox"/> Tremors                         | <input type="checkbox"/> Mid back pain or stiffness R.L.              | <input type="checkbox"/> Pregnant (now)                    |
| <input type="checkbox"/> Light Bothers Eyes              | <input type="checkbox"/> Pain with cough, sneeze, or strain at stools | <input type="checkbox"/> Hepatitis                         |
| <input type="checkbox"/> Under Stress                    | <input type="checkbox"/> Hip pain R.L.                                | <input type="checkbox"/> Venereal Disease                  |
| <input type="checkbox"/> Crave Sweets or Salt            | <input type="checkbox"/> Foot trouble L.R.                            | <input type="checkbox"/> AIDS / HIV                        |
| <input type="checkbox"/> Eating Disorders                | <input type="checkbox"/> Chest Pain                                   | <input type="checkbox"/> Trouble Sleeping                  |
| <input type="checkbox"/> Trouble Concentrating           | <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Lung Problems                     |
| <input type="checkbox"/> Loss of Memory                  | <input type="checkbox"/> Difficulty Breathing                         | <input type="checkbox"/> Knee Pain                         |
| <input type="checkbox"/> Ear Infections                  | <input type="checkbox"/> Detached Retina                              | <input type="checkbox"/> Glaucoma                          |

Rehabilitative Massage, LLC  
Timothy P. Haster, L.M.T. #10525

**PATIENT HISTORY**

**WHAT IS YOUR HEALTH PHILOSOPHY?** (What should you do to be healthy?) \_\_\_\_\_

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**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

\_\_\_\_\_ Temporary Relief (Help the symptom but do not fix the cause of the problem)

\_\_\_\_\_ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

**WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?**

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1. What are your favorite hobbies or activities to do now? \_\_\_\_\_
2. Are your current problems affecting these activities or hobbies? \_\_\_\_\_
3. What activities are you looking forward to doing in retirement? \_\_\_\_\_
4. Who would you like to be doing these with? \_\_\_\_\_

**ON A SCALE OF 1-10 (10 being the most, and 1 being the least):**

\_\_\_\_\_ How committed are you at being at your maximum health potential?

\_\_\_\_\_ How committed are you to preventing arthritis and maximizing spinal stability?

What surgeries have you had? \_\_\_\_\_

List drugs you now take (prescription and non-prescription): \_\_\_\_\_

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Name other doctors you have seen for this condition: what was done, and for how long? \_\_\_\_\_

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**FINANCIAL POLICY**

WE ARE COMMITTED TO PROVIDING YOU WITH EXCELLENT AND AFFORDABLE HEALTH CARE.

The following policy is designed to help us continue to do so.

**BILLING:** Our patients are expected to make payments in the office at the time of service, unless payment arrangements have been approved in advance by our staff. Pharmacy items such as herbs and supplements must be paid for upon receipt. Payment can be in the form of check, cash, or credit card.

**INSURANCE:** If your treatment is covered by health insurance, you may use your receipt to bill your insurance company by attaching the receipt to your claim form and mailing both to your insurance company. All information needed by insurance companies for reimbursement has been included on the receipt.

**CANCELLATIONS:** If unable to keep an appointment, please give us 24 hours notice. **IF YOU FAIL TO KEEP YOUR APPOINTMENT OR CANCEL WITHOUT PRIOR NOTICE, THERE WILL BE A FULL OFFICE FEE.**

I have read and understand the above information and agree to the conditions set forth.

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