Morningstar Therapeutic Massage

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ DOB: _____

In Case of Emergency Notify: _____ Phone: _____

Referred By: _____

Why are you seeking massage therapy? _____

****

General Medical Information (This will be discussed and clarified with your therapist before treatment)

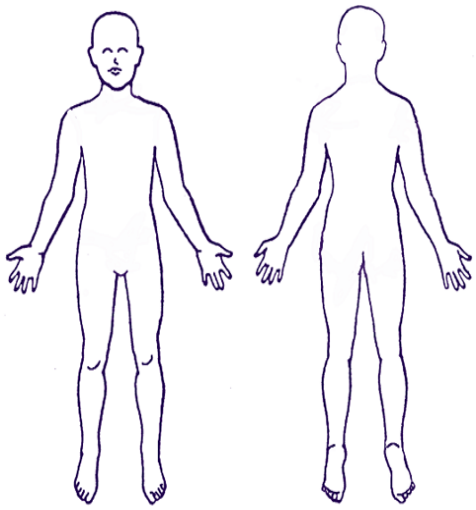
Have you received massage before today?	Y	N	If Yes, how long ago: _____
Are you currently pregnant?	Y	N	If Yes, How many weeks: _____
Are you wearing contacts or prosthetics? (circle one)	Y	N	Location of prosthetic: _____
Are you currently on any medications?	Y	N	If yes, explain: _____

_____

Do you have a history of:

___ Neck pain or Whiplash
___ Back pain- Mid / Low / Disc Problems / Surgeries
___ Headaches / Dizziness / Seizures
___ HIV/Diabetes / Varicose Veins
___ Sprains/Broken Bones / Joint Aches / Decreased Range of Motion
___ Allergies – Oils / Perfumes / Detergents / Other _____
___ Abdominal Pain
___ Arthritis / Bursitis / Gout
___ High Blood Pressure / Stroke / Cancer / Heart Attack
___ Cardiovascular Disease
___ Cosmetic Surgery
___ Any other Surgeries
___ Burns / Bruises
___ Any other condition past or present treated by a physician

Please identify current problem areas with an X



Do you have any of the following today?

___ Sunburn
___ Inflammation
___ Severe Pain
___ Cold / Flu
___ Headache
___ Open cuts / bruise / burn
___ Irritated skin / rash
___ Other condition / concern _____

Please read the following and sign below:

I understand that my therapist needs my current health status in order to treat me effectively. If there are any changes to my health at any time while I am a client I will inform my therapist of these changes as they occur. I understand that massage is not a replacement of medical care and that no diagnosis will be made.

Client (or Gurdian) Signature: _____ Date: _____

Massage Expectations

Please take a moment to carefully read the following information.
Initial all sections after you have read them.
By signing this form, you agree to all statements and have discussed any questions with your massage therapist.

_____ If I have a specific medical condition or specific symptoms, massage/ bodywork may be contraindicated. A referral from my primary care provider may be required prior to services being provided.

_____ Because massage/ bodywork should not be performed under certain medical conditions, I understand that it is important to state all known medical conditions to the therapist and answer all questions honestly. I will also keep the therapist updated about any changes in my medical information and understand that there shall be no liability on the therapists' part if I neglect to do so.

_____ I understand that any illicit or sexually suggestive remarks or advances, abusive language, or personal threats will not be tolerated. The therapist reserves the right to immediately terminate the massage session on these grounds and I will be held liable for payment of full scheduled session time.

_____ I understand that massage/ bodywork is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during my treatment, I will immediately inform the therapist and adjustments will be made to insure my comfort and well-being.

_____ I understand that massage/ bodywork is not a substitute for a medical examination, diagnosis, or treatment. I understand that I should consult a physician, chiropractor, or other qualified medical specialist for any physical or mental ailment that I am aware of.

_____ I understand that Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. Nothing said during the massage session will be construed as such.

_____ I understand that MorningStar's cancellation policy requires me to call and cancel at least 12 hours before my scheduled appointment. If I fail to comply, I may be expected to pay a $25.00 cancellation fee.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

COMPLEMENTARY AND ALTERNATIVE HEATLH CARE CLIENT BILL OF RIGHTS

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STRETEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, athletic trainer, or any other type of health care provider, the client may see such services at any time.

Supervisor's Name: Dr. Catherine Gray
Phone Number: 763.571.0800

Business Address: Morningstar Chiropractic
1210 East Moore Lake Drive
Fridley, MN 55432

The following is the procedure for filing complaints with a supervisor:

Any client may file a complaint with the following office:

Name: Office of Unlicensed Complementary and Alternative Health Care Practice

Address: Minnesota Department Of Health
P.O. Box 64975
121 East 7th Place, Suite 400
St. Paul, MN 55164-0975

Phone Number: 651.282.6319 or
1.800.657.3957

Practitioner fees for unit of services: All sessions will be on a client basis. If your insurance does pay for massage it is the responsibility of the client to get reimbursed from insurance. Other discounts will apply for packages and other promotions, ask your therapist about current specials. Tax is included in the listed prices. Tips are also welcome.

Clients have a right to reasonable notice of changes in services or charges: At least a one month notice will be posted before a fee increase is implemented.

The following is a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to the clients: I will interview my client to determine the best treatment plan for them. Once a plan and treatment goals are discussed I will use various massage modalities and techniques to: promote overall relaxation, increase motion, improve function, decrease pain, decrease stress, increase circulation and promote total body wellness.

- Clients have a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.
- Clients may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
- Client records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.
- Clients have a right to e allowed access to records and written information from records in accordance with Minnesota Statute 144.335.
- Clients have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance or other health programs.
- Clients have the right to coordinated transfer when there will be a change in the provider of services.
- Clients may refuse services or treatment, unless otherwise provided by law.
- Clients may assert the client's rights without retaliation.

Subd. 2. [ACKNOWLEDGMENT BY CLIENT.] Prior to the provision of any services, a complementary and alternative health care client must sign a written statement attesting that the client has received the complimentary and alternative health care client bill of rights.

I hereby acknowledge receipt of the Client Bill of Rights and the attached documents incorporated therein, and I have had a full opportunity to ask questions I have about this document and my rights as a client. I understand my rights as a client.

_____

Printed Name Signature Date