

Client Health Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Date of Birth: _____ Who referred you to this office? Name: _____
 Yellow Pages Advertisement Website Other:

What is your major complaint or condition you want to improve? _____

When did you first notice major complaints? _____

What brought it on? _____

What activities aggravate the condition? _____

Is this condition getting progressively worse? Yes No

Does this condition interfere with work? Yes No Sleep? Yes No Daily Routine? Yes No

Has there been a medical diagnosis? Yes No If so, by whom? _____

Have you had X-rays taken? Yes No

Are you now under medical/therapeutic treatment? Yes No

If yes, for what condition? _____

List any medications (including aspirin) and nutritional supplements you are taking: _____

Please list (date and description) any accidents or operations: _____

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Health History

Put a “P” where you have had a condition in the past. Put a “check” for conditions that apply to you currently. Please add your comments to clarify conditions.

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendinitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Seizure Disorder
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System

- Pregnancy:
- Pelvic Inflammatory Disease
- Endometriosis
- Norplant
- Prostate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list) _____
- Other congenital or acquired disabilities (please list) _____
- Other: _____

Please list any additional comments regarding your health and well-being: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Complimentary & Alternative Health Care Client Bill of Rights

Practitioner Name: Ronald Tuck

Business Name: Ron Tuck Therapeutic Massage

**Business Address: 522 Beltrami Ave NW Suite #108
Bemidji, MN 56601**

Telephone number: (218) 368-3628

As of July 1, 2001, Minnesota's Freedom of Access to Complementary Care Law (Statute Chapter 146A) requires that you receive and acknowledge that you have received by your signature on the bottom of this page, the following information prior to your treatment.

Ron Tuck nctm, hereafter, "the Practitioner" has the received following education, training & credentials:

Massage Therapy Diploma – Northwest Technical College, 2005
NCTM- Nationally Certified for Therapeutic Massage by the National Certification Board of Therapeutic Massage and Bodywork-2005
Myofasial Techniques- Pete Whitridge seminar, 2005
Clinical Ethics- Sandy Fritz Seminar, 2006
Chair Massage- Russell Borner Touch Pro Technique Seminar, 2006
Orthopedic Assessment- Whitney Lowe, 2007
Medical Massage; Ralph Stephens Lumbar / Pelvis / Cervical Seminar, 2007; Shoulder girdle / Abdomen Seminar, 2008
Anatomy Trains; Eli Thompson structural Integration Seminar, 2007
CranioSacral Therapy Seminar, 2008

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. Under Minnesota law, an unlicensed complementary and alternative 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, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time."

- **Complaints:** If the Client has a complaint or concern about the care or services they have received, the Client may also contact the Office of Unlicensed Complementary and Alternative Health Care Practice located in Minnesota Department of Health:
 - **Mailing address:** P.O. Box 64882, St. Paul, MN 55164-0882
 - Phone:** 651-201-3728 **Fax:** 651-201-3839
 - Website:** www.health.state.mn.us **E-mail:** richard.hnasko@state.mn.us
- **Fees, Payment, Insurance:** Fees for Massage Therapy at the Practitioner's office are as follows, with all taxes included: \$35 for 30 minutes, and \$60 for 60 minutes, or \$90 for 90 minutes. Payment is accepted by cash or check. This Practitioner is not on contract with any HMO's, PPO's, or any other Insurance Company to provide discounted services. Payment in full for services is expected at the time of service, unless otherwise arranged prior to the appointment. Ron Tuck Therapeutic Massage requires 24 hours notice for cancellations.
- **Change of Price:** While changes in session fees can occur, reasonable notice of those changes is provided by session fees being posted in the Practitioner's office, or by the client asking when scheduling the appointment.
- **Theory of Treatment:** The Practitioner utilizes Deep Tissue Massage, Myofascial Release and Swedish-Style Relaxation Massage techniques to help his clients reduce pain, improve circulation of blood and lymph and improve range of motion and mobility
- **Right to Current Information:** Clients have the 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.
- **Right to Confidentiality:** Client records are confidential and will not be released, unless authorized by the client in writing or as otherwise provided for by law.
- **Right to Self Access:** Clients have the right to access to their own records maintained by the Practitioner's office, in accordance with state statute sections 144.291 to 144.298;
- **Personal Interaction:** Clients have the right to expect courteous treatment, free from verbal, physical, or sexual abuse.
- **Other Treatment Available:** Other massage therapy services are available to the Client in this same community. These can be located by asking the Practitioner, the provider who referred you to this practitioner or the following practitioner database: www.amtamassage.org
- **Right of Agency:** The Client has 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
- **Records Transfer:** The Client have the right to coordinated transfer of your records when there will be a change in the provider of services
- **Right of Refusal:** The Client may refuse services or treatment, unless otherwise provided by law.
- **Right of Nonretribution:** The Client has the right to assert the any and all of above-mentioned rights without retaliation from the Practitioner.

I _____ acknowledge by my signature that I have received and understand the Complementary and Alternative Health Care Client Bill of Rights.

Signature _____ Date _____

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