



A Balanced Approach To Wellness, Inc.

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Client Health History Form

In order to maximize the effectiveness and safety of massage sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Use an extra sheet of paper if more space is needed and be sure to reference the question number. Your feedback is also appreciated during and at the end of the sessions to help in tailoring the massage session to serve in the best possible way. Please print clearly.

Name: _____ Today's Date: ____/____/____

Home Address _____ City, State _____ Zip: _____

Date of Birth: ____/____/____ Email: _____

Cell #: _____ Home # _____ Work #: _____

Occupation(s): _____

Following if Applicable:

Referred by: _____ Physician: _____ Chiropractor: _____

Have you had any previous experience with massage? YES [] NO []

If yes, please explain whether for stress or relief/relaxation or treatment of a specific condition: _____

Do you have high blood pressure? YES [] NO [] I'M NOT SURE []

Please mark [X] for all conditions that apply now. Put a [P] for past conditions.

Joint/Soft Tissue Discomfort

- Arms
- Neck
- Shoulders
- Upper Back
- Mid Back
- Low Back
- Degenerative Discs
- Feet
- Hands
- Hips
- Knees
- Legs
- Jaw
- Rheumatoid Arthritis
- Osteo Arthritis
- Sciatica
- Limitation of Movement
- In which joints _____
- Other _____

General Symptoms

- Fainting
- Dizziness
- Loss of Sleep
- Fatigue
- Nervousness
- Numbness
- Tingling
- Paralysis
- Headaches (Tension)
- Migraines

Eye, Ear, Nose, Throat

- Allergies
- Hay Fever
- Sinus Infection
- Frequent Colds
- Glasses or Contacts
- Hearing Aid
- Hearing Loss
- Swollen Glands

Infectious

- Hepatitis
- Tuberculosis
- HIV
- Herpes
- Cold
- Flu
- Athlete's Foot
- Warts
- Other _____

Respiratory

- Pneumonia
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Other _____

Cardiovascular

- Heart Attack
- Heart Disease
- Phlebitis
- Stroke/CVA
- Palpitations
- Varicose Veins
- Swollen Ankles
- Poor Circulation
- Pacemaker
- Heart Murmur

Digestion

- Ulcer
- Diarrhea
- Constipation
- Nausea
- Other _____

Explain any areas noted above and note if you are currently seeing a doctor for any of the conditions:

Current medication you are taking including common nonprescription medications:



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List all vitamins, herbs, mineral supplements, etc.:

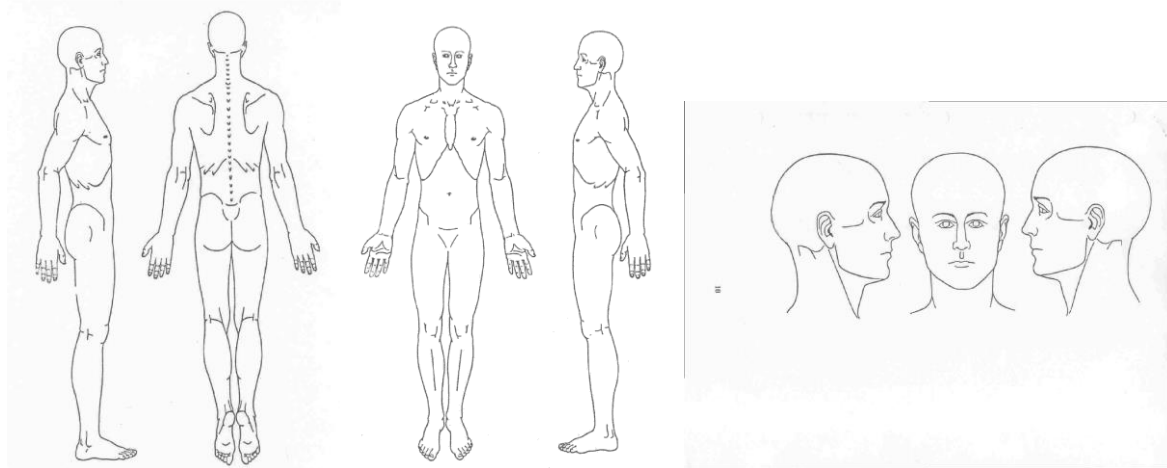
Have you had any surgeries within the last five years? If yes, please explain:

Please list all forms and frequency of stress-reduction activities (hobbies, exercise, sports participation, etc.):

What is your goal/concern for today's session? _____

PAIN & DISCOMFORT CHART

Please indicate the areas where you have pain and describe the level of discomfort using a scale of 1-10 - (A score of 1 being almost no pain and 10 being the highest level of discomfort.) If your pain seems to refer or "shoot out" to another area of your body please indicate with arrows.



For how long have you experienced pain/discomfort in indicated areas?

Describe what you do that causes pain, and what activities make it worse:



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I understand that payment is due at the time of treatment unless other arrangements have been made prior to the session. I agree to give at least 24-hours advanced notice should I need to cancel an appointment; I understand that I will be responsible for payment of missed sessions. Cases of extreme emergency are considered exceptions to the cancellation policy.

If you have a specific medical condition or specific symptoms, massage work may be contraindicated. A referral from your primary care provider may be required prior to services being provided. Please take a moment to carefully read the following information and sign where indicated.

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and / or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or the qualified medical specialist of any mental or physical 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, and that nothing said in the course of the sessions(s) given should be construed as such. Because massage therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

Client Signature

Date

Therapist Signature

Date

Massage session options and pricing at ABAWellness (tax included) are posted on www.abalancedapproach-wellness.com :

The therapist can answer questions regarding the appropriate massage session for your individual needs. Full session fee is due at the time of the massage. Cash, check, and Visa/MC accepted as payment. Any changes to fees will be posted in the lobby and on the website www.abalancedapproach-wellness.com, 30 days in advance of the change. Personal injury insurance is currently the only insurance that regularly covers massage therapy in Illinois and massage therapy cannot be provided for a personal injury case without the referral and prescription from a chiropractor or physician.

Client Signature

Date

Therapist Signature

Date

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HIPAA NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Pledge: *As a professional massage therapy office, we understand that information about you and your health is personal. We are committed to protecting your Protected Health Information (PHI). We create a record of the care and services you receive. These records may include session notes and your personal contact information. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by the office. This notice will tell you about the ways in which we may use and disclose PHI about you. It also describes your rights and certain obligations we have regarding the use and disclosure of information.*

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

The following categories describe different ways that we use and disclose information.

- **For Treatment:** We may use information about you to provide you with treatment or services, or to coordinate care with other medical personnel such as your physical therapist, or chiropractor.
- **For Payment:** We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.
- **For Appointment Reminders and Follow-up:** We may use and disclose PHI to contact you as a reminder that you have an appointment. We may use and disclose PHI to contact you for follow-up phone calls.
- **Treatment Alternatives:** We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services:** We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you. For example, support groups.
- **As Required By Law:** We will disclose PHI about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations:

- **Military and Veterans:** If you are a member of the armed forces, we may release PHI about you as required by military command authorities.
- **Workers' Compensation:** We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks:** We may disclose PHI about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report child abuse or neglect to notify the appropriate government authority if we believe a patient has been the victim of abuse or neglect. We will only make this disclosure when required or authorized by law.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release PHI if asked to do so by a law enforcement official under the following circumstances: In response to a court order, subpoena, warrant, summons or similar process; To identify or locate a suspect, fugitive, material witness, or missing person; About the victim of a crime if, under certain limited circumstances,

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we are unable to obtain the person's agreement; About a death we believe may be the result of criminal conduct; In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

YOUR RIGHTS REGARDING INFORMATION ABOUT YOU

You have the following rights regarding information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and copy PHI that may be used to make decisions about your care. *To inspect and copy:* PHI that may be used to make decisions about you, you must submit your request in writing to the office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend:** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office. *To request an amendment,* your request must be made in writing and submitted to the massage therapy office. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the PHI kept by or for us; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete.
- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of PHI about you. To request this list or accounting of disclosures, you must submit your request in writing to us. Your request must state a time period which may not be longer than six years and may not include dates before January 1st, 2007. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment or payment. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the waiting room. The notice will contain the effective date.

COMPLAINTS: If you believe your privacy rights have been violated, please address your concern first to your therapist. Then, if your concern has not been answered satisfactorily, you may file a written complaint to the Secretary of the Department of Health



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and Human Services. To report any violation of HIPAA, you may use the toll-free number 1-800-TELLUSO. You will not be penalized for filing a complaint.

OTHER USES OF PHI: Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

(Client) _____ Date
I acknowledge receipt of the Notice of Privacy Practices.

Authorized representative _____ Date



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Complementary and Alternative Health Care Client Bill of Rights

As of July 1, 2001 the Freedom of Access to Complementary Health Care Law requires that you receive and acknowledge that you have received by your signature the following information prior to your treatment.

Under Illinois State 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.

If you have concerns regarding the quality of your care, you have the right to file a complaint with the State of Illinois. Any such concern should **first** be directed to the attention of the Massage Therapist. If your concerns are not resolved, you may submit your concerns in writing to the Health Occupations Program and should include supporting details sufficient to permit the start of an investigation into the concern.

Massage is a manual therapeutic procedure that uses touch to treat the soft tissue structures of the body. When the body is touched, receptors in the skin send messages to the brain causing the release of chemicals such as endorphins. These produce a sense of relaxation and wellbeing and can also relieve pain. Massage also improves the flow of blood and lymph fluid, helps to eliminate waste products from the body, relaxes the muscles and can help regulate hormone production and stimulate the immune system. It's also useful for specific ailments such as asthma, depression, neck and back pain, insomnia, immune deficiency disorders and diabetes. My intent as a therapist is to promote increased health and well-being for my clients using Western-Style Swedish Massage, Trigger Point Therapy and Muscle Energy Techniques.

As a consumer of Complementary and Alternative Health Care, you have the following rights:

- ✔ The right to complete and current information concerning assessment and services provided including the duration of the service to be provided.
- ✔ The right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
- ✔ The right to confidential client records and transactions with the practitioner, unless release of these records is authorized in writing by the client, or otherwise provided by law.
- ✔ The right to be allowed access to records and written information from records in accordance with section [144.335](#).
- ✔ The right to getting a referral to other services may be available in the community, including where information concerning services is available.
- ✔ 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.
- ✔ The right to coordinated transfer when there will be a change in the provider of services.
- ✔ The right to refuse services or treatment, unless otherwise provided by law.
- ✔ The right to assert your rights without retaliation.

I have received the Complementary and Alternative Health Care Client Bill of Rights.

Client

Date

Therapist