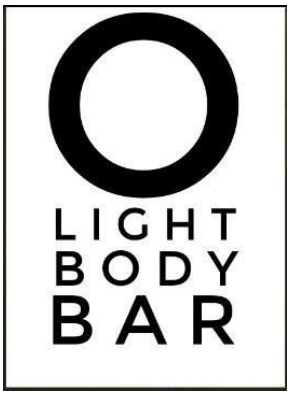


55 Portion Rd.
Lake Ronkonkoma, NY 11779

Name: _____

Address: _____

_____

Gender: M / F DOB: _____ SS#_____

Email Address:_____

Phone: (_____) _____ Cell: (_____) _____

Occupation/Employer:_____

Marital Status: Single / Married / Divorced / Separated / Widowed

Insurance: _____ Policy Number: _____

Pulse:_____ Blood Pressure: _____ Height: _____ Weight: _____

Have you ever had a professional therapeutic massage before? YES / NO

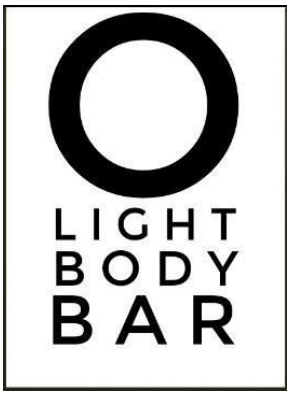
Last treatment: _____ How often:_____ Types of Massage:_____

Have you ever had chiropractic care before? ☐YES ☐ NO

Last treatment: _____ How often:_____ Dr Name:_____

Have you ever had acupuncture before? YES NO

Last treatment: _____ How often:_____ Acupuncturist Name:_____



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Past/Current Illness: (Check all that apply)

Musculoskelatal

____ Bone or Joint Disease
____ Tendonitis/Bursitis
____ Arthritis/Gout
____ Jaw Pain (TMJ)
____ Lupus
____ Spinal Problems
____ Migraines
____ Oseoporosis

Circulatory

____ Heart Condition
____ Phlebitis/Varicose Veins
____ Blood Clots
____ High/Low Blood Pressure
____ Lymphedema
____ Thrombosis/Embolism

Respiratory

____ Difficult Breathing/ Asthma
____ Emphysema
____ Sinus Problems

Nervous System

____ Shingles
____ Numbness/ Tingling
____ Pinched Nerve
____ Chronic Pain
____ Paralysis
____ Multiple Sclerosis
____ Parkinson's Disease

Reproductive

____ Pregnant ____ weeks
____ Ovarian/ Menstrual Prob
____ Prostate

Skin

____ Rashes
____ Cosmetic Surgery
____ Athlete's foot
____ Herpes/Cold sores

Digestive

____ IBS
____ Bladder/Kidney Ailment
____ Colitis
____ Crohn's Disease
____ Ulcers

Other

____ Cancer
____ Diabetes
____ Drug/Alcohol/Tobacco
Frequency_____

Please list any devices: (hearing aid/dentures/contacts/prosthetics/implants/etc)_____

_____

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Past Surgeries/Traumas:_____

_____

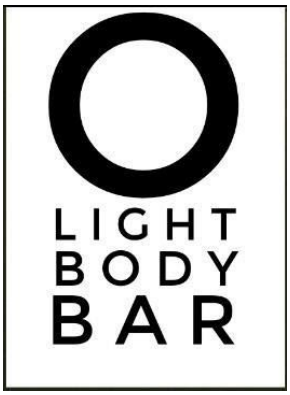
Emotional/Mental Health Issues: (Anxiety / Depression / PTSD / Other) Specify:_____

_____ Nervous Habits: _____

Medications:

Drug / Dose	Purpose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:_____



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Family Medical History:

Mom: _____
Age / Illnesses

Dad: _____
Age / Illnesses

Sibling: _____
Age / Illnesses

Sibling: _____
Age / Illnesses

Sibling: _____
Age / Illnesses

Current Complaints:_____

_____

_____

Is this affecting your daily routine?_____

What limitations do you suffer from due to this condition?_____

What activities aggravate your condition?_____

What feels better?_____

What feels worse?_____

Do you have any treatment goals?_____

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Credit Card Authorization Form

Credit Card Information:
Card Type: ☐ MasterCard ☐ Visa ☐ Discover ☐ AMEX ☐ Other: _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date: (mm/yy) _____/ _____ Security Code: _____
Cardholder ZIP code (from billing address): _____

I, _____, authorize O Light Body Bar to charge my credit card above for agreed upon purchases, including cancellation policy below. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

Cancellation Policy

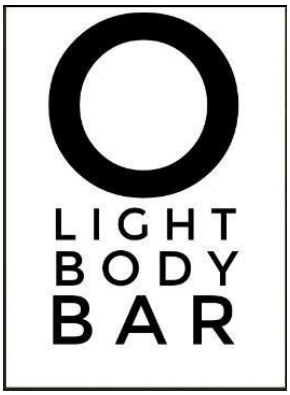
We understand that situations arise that it is necessary to cancel or reschedule your appointment. We ask that you give **24 hours notice.**

Appointments cancelled **within 24 hours** will receive a **$45 minimum cancellation fee or 30% of the cost of services booked** and applied to your credit card.

Further, **NO SHOWS WILL BE BILLED IN FULL.**

I, _____, agree to the terms of this cancellation policy.

_____ _____
Customer Signature Date



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Client Agreement:

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent or massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examinations or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

_____ _____

Signature of patient or parent/guardian Date

_____

Print Name

****

How did you hear about us?

- ❑ Facebook
- ❑ Instagram
- ❑ LinkedIn
- ❑ Google
- ❑ Massage Anywhere
- ❑ AMTA
- ❑ Street sign
- ❑ Open House Flyer (located where?_____)

- ❑ Referral (Name:_____)

Questions/Comments/Concerns:_____

_____

Emergency Contact: _____

Phone Number: (_____) _____ Relationship to Patient: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____- _____ -_____

Printed Name **Signature** **Date**

HIPAA

NOTICE OF PRIVACY FOR PATIENT'S PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for our privacy have been attained.
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-In logs may be disclosed to verify office visits.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.

I acknowledge that I have received and reviewed this notice with full understanding.

_____

Name of Patient (print) Signature of Patient/Legal Representative Date