

**Tissue Release Therapy, LLC**  
16782 21 Mile Road  
Macomb, MI 48044  
Located inside Pursuit Chiropractic

**Confidential Health History Form**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_

Medications: \_\_\_\_\_

Vitamins/Supplements: \_\_\_\_\_

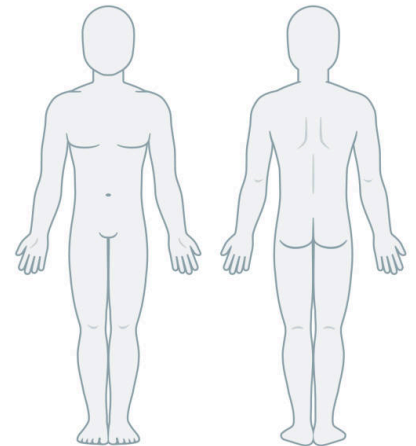
Allergies: \_\_\_\_\_

Primary reason for appointment: \_\_\_\_\_

When did you first notice these concerns? \_\_\_\_\_

Is this condition becoming progressive? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Constant \_\_\_\_ Intermittent

Make an X on the picture where your symptoms are present:



Does your condition involve?: \_\_\_\_ Pain \_\_\_\_ Numbness \_\_\_\_ Tingling \_\_\_\_ Swelling

Please rate the severity of your condition from 1 (least pain) to 10 (severe pain): \_\_\_\_\_

Describe/circle the type of pain you have: dull / sharp / stabbing / throbbing / aching / shooting / burning / cramping / stiffness: \_\_\_\_\_

How are these symptoms affecting your daily function? \_\_\_\_\_

- Work: \_\_\_\_\_
- Leisure/Play: \_\_\_\_\_
- Self-care/sleep/appetite: \_\_\_\_\_

Circle the activities that are painful to perform: sitting / standing / walking / bending / laying

Have you ever received treatment for your condition? \_\_\_ Yes \_\_\_ No \_\_\_ Currently Receiving

- If so, what treatment and where? \_\_\_\_\_

Please state your goals for therapy: \_\_\_\_\_

**Exercise:** Please describe your routine: \_\_\_\_\_

**Work Activity:** \_\_\_ Sitting \_\_\_ Standing \_\_\_ Light labor \_\_\_ Heavy labor \_\_\_ Mixed

**Habits:**

\_\_\_ Smoking. Packs/day \_\_\_

\_\_\_ Alcohol. Drinks/week \_\_\_

\_\_\_ Coffee/caffeine. Cups/day \_\_\_

**Stress:** Do you experience stress? \_\_\_ Yes \_\_\_ No

Cause of stress: \_\_\_\_\_

Where do you hold stress in your body?: \_\_\_\_\_

**Toxicity:** List all known toxicities & treatment regimens: \_\_\_\_\_

**Elimination:** Urine output: \_\_\_\_\_ times/day      Bowel movements: \_\_\_\_\_ times/day

**Significant Injuries** (falls, accidents, head injuries, fractures, birth traumas, etc.).

- Please describe and date: \_\_\_\_\_

**Surgeries:** Please describe and note: \_\_\_\_\_

Please check any symptoms or conditions which apply or may have applied to you, and star any conditions which are currently significant:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Acute Infection        | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Pregnancy              |
| <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Prostate Problems      |
| <input type="checkbox"/> Allergy Shots          | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Prosthesis             |
| <input type="checkbox"/> Anemio                 | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Psychiatric Care       |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Immunization Reaction  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Herniated Disc          | <input type="checkbox"/> Sinusitis              |
| <input type="checkbox"/> Autism/POD             | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Skin Disorder          |
| <input type="checkbox"/> Breast Lump            | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Infertility             | <input type="checkbox"/> Suicide Attempt        |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Scars: _____           |
| <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Learning Disorder       | <input type="checkbox"/> Paralysis: _____       |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> TMJ Dysfunction        |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Loss in Range of Motion | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Lymph Node Removal      | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Chronic Fatigue        | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Closed Head Injury     |
| <input type="checkbox"/> Contagious Disease     | <input type="checkbox"/> Miscarriage             | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Constipation/Diarrhea  | <input type="checkbox"/> Mononucleosis           | <input type="checkbox"/> Tumor(s): _____        |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Toxicity               |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Muscle Spasms           | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Digestive Problems     | <input type="checkbox"/> Neurological Disorder   | <input type="checkbox"/> Varicose Veins         |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Vaginal Infections     |
| <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Parkinson's Disease     | <input type="checkbox"/> Venereal Disease       |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Pinched Nerve           | <input type="checkbox"/> Vision Problems        |

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

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

**Tissue Release Therapy, LLC**  
**Policies & Procedures**

Welcome to Tissue Release Therapy, LLC. Congratulations on taking a vital step towards improved health and well-being! The following policies and procedures will help you get the most from your sessions. Please review all policies and sign your name at the bottom, indicating you understand and accept them. If you have any questions, please ask.

1. I understand that the therapy performed here at Tissue Release Therapy, LLC utilizes the principles of Occupational Therapy, CranioSacral Therapy, Graston Technique®, Myofascial Release and/or cupping. I also understand that these therapies do not constitute medical diagnosis or treatment in any way.
2. I agree to take responsibility for alerting my therapist to any changes in my or my child's health status that may affect our treatment sessions.
3. I understand that full payment is required at time of service. Cash or checks are preferred methods of payment. Visa, MasterCard, Discover and American Express are also accepted. There will be a \$30 fee for all returned checks.
4. I understand that most bodywork sessions fit well into a 30-60-minute time frame. If my therapist believes more or less is warranted for my or my child's session, said therapist will notify me ahead of time. Therapist may require prepayment as she feels appropriate. All payments are non-refundable.
5. I understand I can purchase sessions either individually or in a cost-saving package. It must be paid in full at the time of purchase and is non-transferable & non-refundable.
6. I understand that if I need to cancel or reschedule a bodywork session, I must do so at least 24 hours in advance. Failure to do so will result in a charge for the full session scheduled.

**Service Price List**

- 30 minute session = \$65
- 45 minute session = \$90
- 60 minute session = \$100
- 75 minute session= \$120
- 90 minute session= \$140

**Package Price List**

- 5 - 30 minute sessions = \$300 (a \$25 savings)
- 5 - 45 minute sessions = \$420 (a \$30 savings)
- 5 - 60 minute sessions = \$460 (a \$40 savings)
- 5 - 90 minute sessions = \$650 (a \$50 savings)
- Packages expire within 6 months from date of purchase

My name and signature below constitute my agreement with these policies and procedures:

**Patient Name (Please Print).** If Minor, Guardian Name: \_\_\_\_\_

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

**Tissue Release Therapy, LLC**  
**HIPAA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The IDPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? \_\_\_YES \_\_\_NO

May we leave a message on your answering machine ? \_\_\_YES \_\_\_NO

May we discuss your medical condition with any member of your family? \_\_\_YES \_\_\_NO

If yes, please name the members allowed: \_\_\_\_\_

This consent was signed by: \_\_\_\_\_

(Print Name Please)

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_