

Confidential Health Intake Form

Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Work Phone _____ Home phone _____ Cell Phone/pager _____

Emergency Contact _____

Employer _____ Social Security Number _____

Occupation/employer _____

Insurance Information:

Referring Physician: _____ Primary Care Physician: _____

Was Injury a result of an accident? _____ If yes: Job related _____ Auto _____ Other _____

Date of Injury or onset: _____

Insurance Company Name: _____

Billing Address: _____

Phone Number: _____

Contact person/ case manager _____

Name of Insured : _____

Address: _____

Phone: _____

Group/Claim Number/Id number: _____

Attorney (if applicable) Name : _____

Address: _____

Phone number: _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee. (Please note that insurance companies **do not** pay this, you do.)

Signature _____ Date _____

Medical History and Information

Check any or all that apply to your present health:

- | | | |
|--|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chronic pain | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> jaw pain/teeth grinding | <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer/tumors |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> tendonitis | <input type="checkbox"/> skin problems |

Women only: Pregnant Painful menstruation endometriosis

Men only: Prostate problems

List all medications/herbs/vitamins and dosage: _____

List physical activities you participate in regularly _____

What movements or activities are limited? _____

Describe the events of the injury or accident: _____

List previous major injuries/surgeries: _____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): _____

What seems to help the most? _____

What seems to aggravate the condition the most? _____

What is your main activity at work? On phone _____ Sitting _____ Computer work _____

Driving car _____ Walking _____ Other _____

What do you do to relieve stress? _____

What do you want to get out of you session (s)? _____

Practitioner Comments _____