Confidential Health Intake Form

Name _____
Street Address _____
City_____ State_____ Zip_____
Date of Birth _____

Work Phone _____ Home phone_____
Cell Phone/pager_____

Emergency Contact _____

Employer _____
Occupation _____

Referring Physician:_____
Primary Care Physician:_____

Insurance Information:

Was Injury a result of an accident?_____ If yes: Job related_____
Auto _____ Other_____

Date of Injury or onset: _____
Referring Physician_____

Insurance Company
Name:_____
Billing Address:_____
Phone Number:_____
Contact person/ case manager _____

Name of Insured :_____
Address:_____
Phone:_____

Group/Claim Number: _____

Attorney (if applicable)
Name :_____
Address:_____
Phone number: _____

Applicable only to insurance work:

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.

Applicable to all massage recipients:

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:

___ headaches ___chronic pain ___varicose veins

___ vision problems ___muscle or joint pain ___blood clots

___ sinus problems ___numbness/tingling ___high/low blood pressure

___ jaw pain/teeth grinding ___sprains/strains ___diabetes

___ fatigue ___scoliosis ___cancer/tumors

___ depression ___arthritis ___infectious disease

___ sleep difficulties ___tendonitis ___skin problems

Women only: Pregnant___ Painful menstruation___ endometriosis___

Men only: Prostrate problems___

List all medications/herbs/vitamins and dosage:
_____

_____

List physical activities you participate in
regularly_____

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):
_____

_____

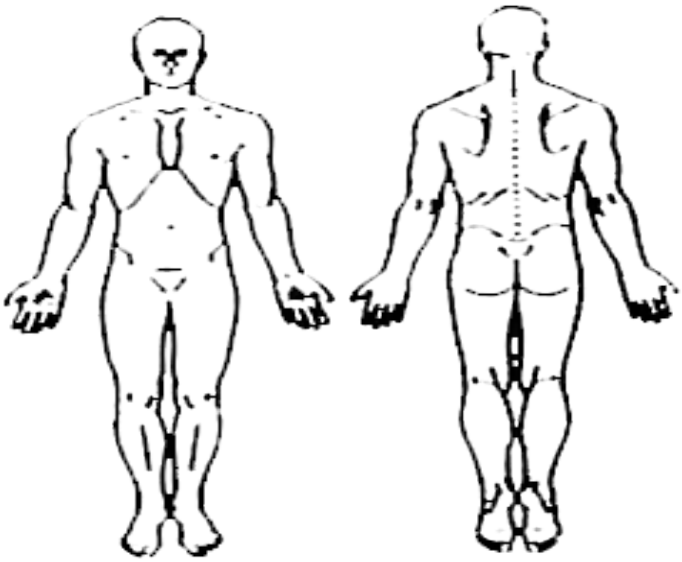
What seems to help the most?
_____

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_____
_____

Practitioner Comments_____
_____
_____

Please mark areas of discomfort and describe symptom: