Personal Data This information is needed to establish your medical chart. Please fill out completely.

Name:_____ Date:_____

Address: _____ Occupation:_____

City/State:_____ Zip: _____ Phone-:_____

Birthday: _____ Email Address:_____

Referring Medical Provider : _____ Phone:_____

Permission to consult with medical provider? Please initial: [X] Yes_____

Emergency Contact: _____ Phone:_____

Massage History and Treatment

Ever received a professional massage? [ ] Yes Frequency _____ Date of last massage_____ [ ] No

Results you should expect to see from your massage sessions: Relief for injuries sustained in motor vehicle accident _____
_____

Areas of your body that will receive massage treatment: ____As stated by referring medical provider / primary care physician ____ **Please initial here: _____** to acknowledge permission to receive massage for **ALL AREAS STATED ON DOCTOR'S REFERRAL**

Please initial here: _____ I am currently under a doctor's care for injuries sustained in a motor vehicle____ accident_____

List stress reduction exercise activities and include frequency. _____
_____
_____

List current medications, including aspirin, ibuprofen, etc. _____
_____
_____

Previous History (Include year and treatment received)

Surgeries: _____
_____
_____

Accidents: Motor Vehicle Accident _____
_____
_____

Health History

Musculo-Skeletal
___ Bone or joint disease _____
___ Tendonitis _____
___ Bursitis _____
___ Broken/Fractured Bone _____
___ Arthritis _____
___ Sprains/Strains _____
___ Low Back, Hip, Leg Pain _____
___ Neck, Shoulder, Arm Pain _____
___ Headaches/Head Injuries _____
___ Spasms/Cramps _____
___ Jaw Pain/TMJ _____
___ Lupus _____
___ Other _____

Circulatory
___ Heart Condition _____
___ Varicose Veins _____
___ Blood Clots _____
___ High Blood Pressure _____
___ Low Blood Pressure _____
___ Lymphedema _____
___ Breathing Difficulty _____
___ Sinus Problems _____
___ Allergies _____
___ Other _____

Infectious Disease
___ Disease Name(s) _____
_____
_____

Skin
___ Allergies _____
___ Rashes _____
___ Athletes Foot _____
___ Warts _____
___ Other _____

Digestive
___ Constipation _____
___ Gas/Bloating _____
___ Diverticulitis _____
___ Irritable Bowel Syndrome _____
___ Other _____

Nervous System
___ Herpes/Shingles _____
___ Numbness/Tingling _____
___ Chronic Pain _____
___ Fatigue _____
___ Sleep Disorder _____
___ Other _____

Reproductive
___ Pregnant? Stage _____
___ PMS _____
___ Other _____

Other
___ Cancer/Tumors _____
___ Diabetes _____
___ Eating Disorders _____
___ Depression _____
___ Drug/Alcohol Addiction _____
___ Nicotine/Caffeine Addiction _____

It is my choice to receive massage therapy. I realize that the treatment is being given for my well-being. This includes stress reduction, relief from muscular tension, spasm or pain.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

I authorize the release of any medical or other information necessary to process PIP , L&I, health insurance claims (if applicable), legal claims or account collections. ***(The Massage Clinic does not accept health insurance).***

Please sign Yes:_____

Print Name: _____ Date: _____

The Massage Clinic, Inc. Date_____

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspection and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time. The effective date at the top right hand side of this page indicated the date of the most current notice in effect.

You have the right to receive a copy of the most current notice in effect, if you nave not reserved a copy of our current notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the notice or your medical information, please contact Kim Newman in our office at 4322 Rucker Ave, Everett, WA 98203 (425) 258-5454

I_____ have read and understand the information above.

Please check all that apply:

_____ I received a copy of the Notice of Privacy Practices

_____ I have had an opportunity to read the Notice of Privacy Practices.

PLEASE SIGN HERE:_____

Insurance Verification

Complete only the areas highlighted in yellow. This information is required.

Date: _____ Date of Injury: _____

Patient Name: _____ Patient Birth Date: _____

Social Security Number: _____

PIP Auto Insurance Company
Name or Attorney Name: _____

This is (circle one): My insurance Other Party's Insurance

Insurance address or Attorney
address: _____

Claim Number: _____

Insurance or attorney Phone: _____
(optional)
Employer Name: _____ Employer Phone: _____

To be completed by The Massage Clinic
Name of Claims Adjuster: _____

Has the patient received prior Massage Therapy for this claim? ☐ Yes ☐ No

With whom? _____

Number of Massage treatments received elsewhere? _____

What is the copayment or coinsurance? Amount: _____

What is the annual limit: (☐ dollar or ☐ visits)? _____

Is massage therapy covered by a massage therapist? _____

Notes: _____

_____

_____

_____