HISTORY / INTAKE FORM

PAGE ONE

PATIENT: _____

Address: _____ State: _____ Zip: _____

DATE OF BIRTH: _____ HOME PH: _____

OCCUPATION: _____ WORK PH: _____

HOW LONG: _____ EMAIL ADDRESS: _____

SPOUSE: _____ SPOUSE WORK #: _____

INSURANCE: NAME OF COMPANY: _____

Date of Incident _____ GROUP: _____

CLAIM / POLICY #: _____ REF BY: _____

S. S. #: _____ ADJUSTER_____

DOCTOR: _____ **ATTORNEY:** _____

PHONE #: _____ PHONE: _____

ADDRESS: _____ **ADDRESS:** _____

CITY: _____ CITY: _____

STATE: _____ ZIP: _____ STATE: _____ ZIP: _____

EMPLOYER*:* _____

COMPANY: _____PHONE: _____

SUPERVISOR: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP:_____

NOTIFY/ EMERGENCY: _____PHONE: _____

Nearest relative, not living with you? _____

HOW WILL PAYMENT BE MADE?

☐ AUTO INSURANCE: ☐ WORKERS' COMPENSATION: ☐ MAJOR MEDICAL: ☐ CASH:
☐ ATTORNEY LIEN: ☐ CREDIT CARD: ☐ CHECK:
☐ OTHER:_____
☐ CREDIT CARD: TYPE:_____CARD #_____EXP. DATE:_____

HISTORY/ INITIAL INTAKE FORM

PAGE TWO

- Was this case related to Work ☐ Auto ☐ or Other ☐ Explain _____
- How did it happen? _____
- If it happened at work, was the employer notified? Yes ☐ No ☐
- Has the insurance company been notified? Yes ☐ No ☐
- Are you presently employed? Yes ☐ No ☐
- Occupation: _____
- If work related, are you working for same employer? Yes ☐ No ☐
- Are you presently under a doctor's care? Yes ☐ No ☐
- Have you ever been treated for the same condition? Yes ☐ No ☐
- Were you admitted to the hospital? Yes ☐ No ☐ How long? ☐
- What makes your condition worse? _____
- Surgery in past 4 years Yes ☐ No ☐ If yes, Explain: _____
  _____
  _____
- Smoke Yes ☐ No ☐ Use alcohol Yes ☐ No ☐ Tea Yes ☐ No ☐ Caffeine Yes ☐ No ☐

  Coffee Yes ☐ No ☐ Chocolate Yes ☐ No ☐ Eat red meats Yes ☐ No ☐
- If female, are you pregnant Yes ☐ No ☐ Date due:_____ Wear Contacts Yes ☐ NO ☐

- High blood pressure Yes ☐ No ☐ If yes, approx. how high? _____ /_____
- Contagious Diseases Yes ☐ No ☐ If yes, explain _____
- Heart Condition Yes ☐ No ☐ If yes, Explain_____
- Wear Contacts Yes ☐ No ☐
- Varicose Veins Yes ☐ No ☐ Where? _____
- Cancer Yes ☐ No ☐ If yes, where in the system?_____

List three major health complaints and medications you are taking: (use back of form if necessary)_____
_____

Do you have any preexisting conditions that relate to this present injury? Yes__ NO ____If YES, please explain: _____
_____

Client Signature:_____ Date:_____

PERSONAL INJURY /AUTO ACCIDENT or SLIP & FALL CASE

- Do you have No - Fault P. I. P. benefits? YES: ☐ NO: ☐
- Are there benefits left? YES: ☐ NO: ☐
- Do you have a deductible? YES: ☐ NO: ☐
- Deductible amount? $_____ Has it been met yet? YES: ☐ NO: ☐
- If not, how much deductible is left to be met yet $_____
- What percentage does your insurance cover _____ %
- What are the policy limits $_____
- Do you have MED-PAY on your policy? YES: ☐ NO: ☐ (picks up the .20%)
- Do you have U/M (Uninsured Motorist Protection)? YES: ☐ NO: ☐
- Were you cited in the accident? YES: ☐ NO: ☐ Don't know: ☐
- Were you struck from: Behind: ☐ Front: ☐ R. Side: ☐ L. Side: ☐
- If other, please explain: _____
- Did you feel pain immediately? YES: ☐ NO: ☐ Where_____
- If NO, when did you first start feeling pain? _____
- Since the injury are your symptoms: Getting worse: ☐ Improving: ☐
- Staying the same ☐ Changing ☐ (If changing, explain): _____
- Were You the: Driver ☐ Passenger ☐ Pedestrian ☐ Other _____

INFORMATION ON DRIVER OF VEHICLE AT FAULT:

Name: _____ Phone #: _____

Address: _____ Policy #: _____

Have you obtained an attorney for this case YES: ☐ NO: ☐

Attorney or Law Firm Name: _____

ADDRESS: _____

PHONE: _____Fax: _____

Release Of Records / Payment Agreement
And Assignment Of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____ Date:_____

Insurance Company: _____

Physician Referral: _____

Attorney (If applicable): _____

I hereby authorize: Restoration Massage & Bodywork, my Health Care Provider/Facility, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and /or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider /facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to Restoration Massage & Bodywork, my Health Care Provider /Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility /health care provider, received by the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____Date: _____

Witness: _____Date: _____

Practitioner/Clinic Name: Restoration Massage & Bodywork

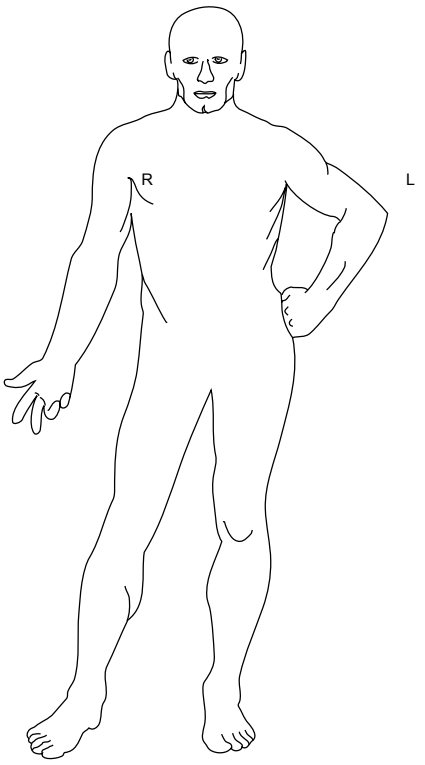
Health Status Update

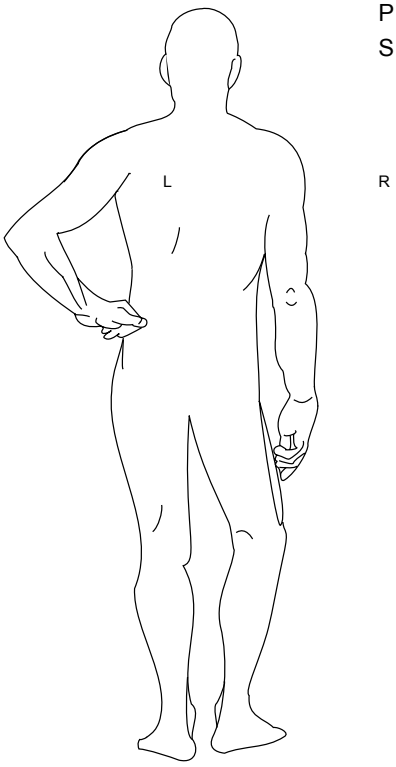
Contact Information: 615-494-3277

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

Depict how you are feeling today by drawing a circle on the figures representing the size and shape of the following symptoms. Place the letter representing the symptoms in or near the circle:





P = Pain, ache, or tenderness
S = Stiffness in the joint or muscle

Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Able to do everything	0	1	2	3	4	5	6	7	8	9	10	Not able to do anything

Comments

Is there anything else I should know about how you are feeling today or about your progress or care to date?

_____

_____

_____

Signature: _____ Date: _____