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:_____

MEDICAL RECORDS RELEASE FORM

To Provider of Services:

Restoration Massage & Bodywork

I hereby authorize you to release to any attorney, physician, or insurance company involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/ illness sustained on: _____/_____/_____.

Printed Name of Patient:_____Date:_____
Signature of Patient:_____ Date:_____

ASSIGNMENT OF BENEFITS

To Insurance Company: _____

Provider of Services: Restoration Massage & Bodywork

I hereby request that you pay directly to this above -mentioned provider of services, any moneys that are due and owing on my case, for services rendered by them to me. This assignment can by submitted by fax or copies and shall be as valid as if it were the original. This assignment may in the future, be revoked by my attorney.

Printed Name of patient:_____Date:_____
Signature of patient: _____ Date: _____/_____/_____.

WORKERS' COMPENSATION FORM

WORK RELATED INJURY INFORMATION

- Has injury been reported to immediate supervisor or foreman Yes ☐ NO ☐
- If yes, Give his or her name: _____
- May I call your employer for authorization to treat you Yes: ☐ NO ☐
- Have you retained a Workers' Comp. attorney for this case Yes: ☐ NO ☐
- Date and time this injury occurred: Date_____Time _____
- Area that you felt pain immediately after the accident _____
- Did you return to work? Yes ☐ NO ☐ Same Company? Yes: ☐ NO ☐
- If not currently working give last date of employment: _____
- Have you ever injured this area before? Yes: ☐ NO ☐
- Did you lose time from work at that time? Yes: ☐ NO ☐
- Do any other medical problems affect your employment? Yes: ☐ NO ☐
- During daily work or activities, do you have to favor any part of your body? Yes ☐ NO☐
- Explain: _____
- Have you ever had a Workers' Compensation claim before? Yes: ☐ NO: ☐
- Since the injury, symptoms are: Improving ☐ Worse ☐ Same ☐ Changing ☐
- If changing explain: _____
- Explain in detail how your accident happened? _____

_____

_____

Patient; Read & Sign Below:

"I understand that once I am an authorized Workers' Compensation Patient, I am not to be billed, by you, your staff, or facility, for services, under any circumstances. The only exception is, unless I am required by law to pay a co-pay after reaching MMI, or unless I, or you are notified by the employer/carrier, through legal avenues that you have been de-authorized. I understand that it is my responsibility to keep all of my appointments with you. I understand also that if I do not, and if I regularly miss appointments, it is then your obligation to notify the employer/carrier & my physician. To regularly or often miss my scheduled appointments is an indication that I may no longer need treatments & can therefore possibly jeopardize my case."

Signed: _____ Date: _____

Practitioner/Clinic Name: Restoration Massage & Bodywork

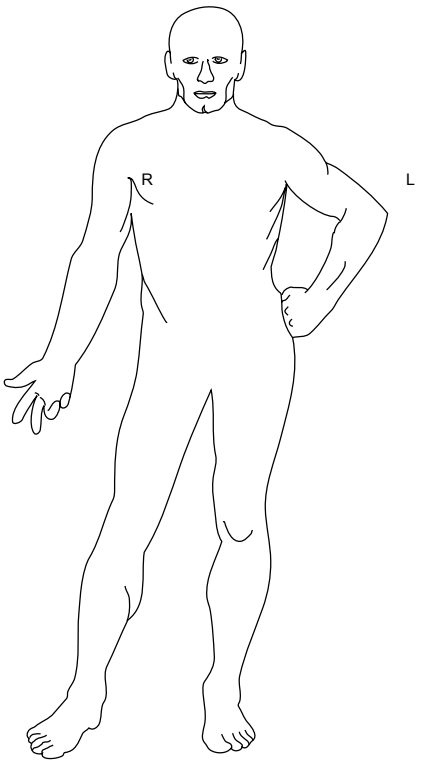
Health Status Update

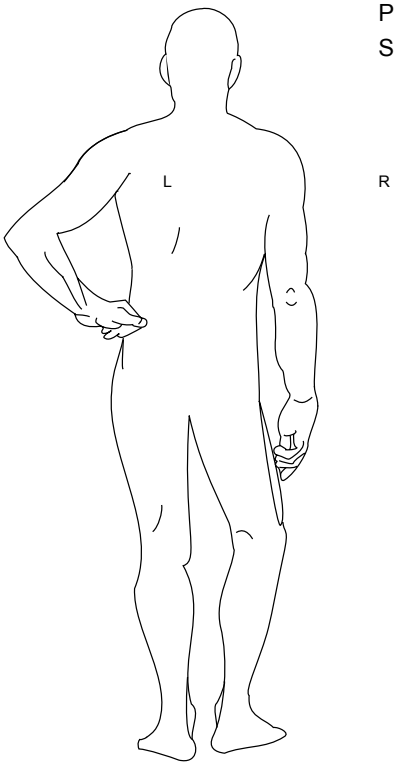
Contact Information: 615-494-3277

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: _____