Heritage Health Massage Intake Form

Name ______________________________ Today's Date _________ Date of Injury _________

Hm Phone _____________ Wk Phone _____________ Cell Phone _____________

Home Address ____________________________ City/State _________/____ Zip Code ________

Employer _________________________ Occupation _________________________

Date of Birth __________ Marital Status: _____________________

Emergency Contact _________________ Relationship ____________ Phone ____________

Who may we thank for referring you to our office? _____________________________________

If you found us in the yellow pages, do you remember which one? __________________________

Is your visit due to an auto accident? Yes/No Is your visit due to another accident (ex. work)? Yes/No

What is your major concern today? ____

When did you receive your last massage? ____

How would you describe your discomfort? ____

Intensity: __________ mild _________ moderate __________ severe __________ other: _________

Duration: __________ constant ______ intermittent _________ with certain motions ____________

What activities are painful? ____

What activities are helpful to do? ____

When did you first notice the pain? ____

What was the onset, if known? ____

Are you currently under the care of a health care practitioner for any reason? _______________________
____

Has there been a medical diagnosis of your pain? ____
____

What are your most frequent activities, at home, work, or other? ______________________________
____

Do you exercise? Yes/No If yes, how often? ____

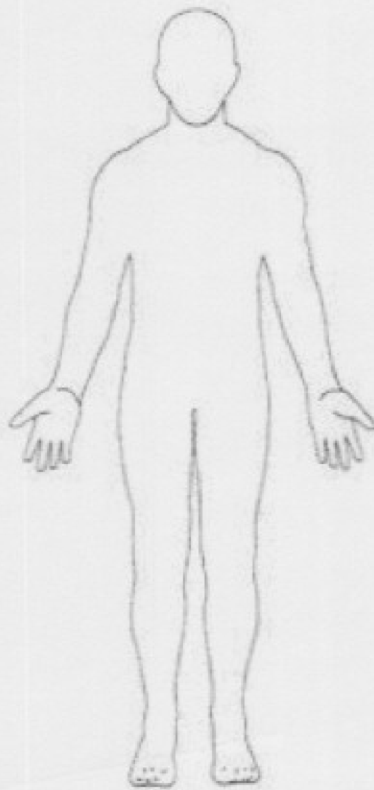
Previous injuries included broken bones NOT requiring surgery: ______________________________
____

Previous surgeries with approximate dates: ____

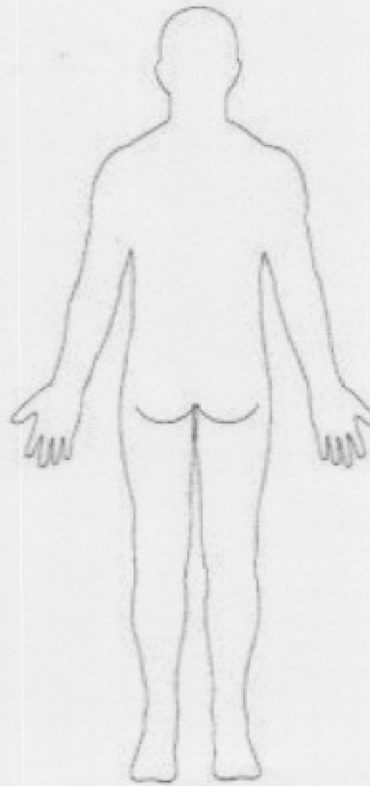
Do you have insurance? Yes/No If no, how will you be paying today? Cash ___ Check ___ Credit Card ___

If yes, we will need to make a copy of your insurance card.
*If you have Great West Insurance, we will need your Social Security Number ______________

Key	
○	Circle areas where **pain** exists
⊙	Circle areas with small dots where **extreme pain** exists
X	Put an "X" over **stiff** areas
≋	Draw squiggly lines over areas of **numbness** or **tingling**
┼┼┼	Mark **scars, bruises** or **wounds**



Front



Back

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare my necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. I hereby authorize Heritage Health and whomever they may designate as their assistants to administer treatment, as they do deem necessary. I authorize the release of my information acquired in the course of my examination or treatment. I certify that the above information is true and correct. I will notify you of any changes in my status or the above information.

Signature ______________________ Date __________ Signature of Parent (if minor) ______________________ Date __________