Patient Information

Date: _____
Patient: _____
DOB: ___/____/____ SSN: _____-____-_____
☐ Female ☐ Male Height: _____Weight: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: _____

Whom May we Thank for referring you? _____
_____

In case of Emergency

Name: _____Relationship: _____
Phone: _____ Work: _____
Would you like email flyers/discounts? ☐ Yes ☐ No
Email: _____

Insurance

Who is responsible for this account? _____
Relationship to patient: _____
Insurance Co: _____ ID#: _____
Insurance Address: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

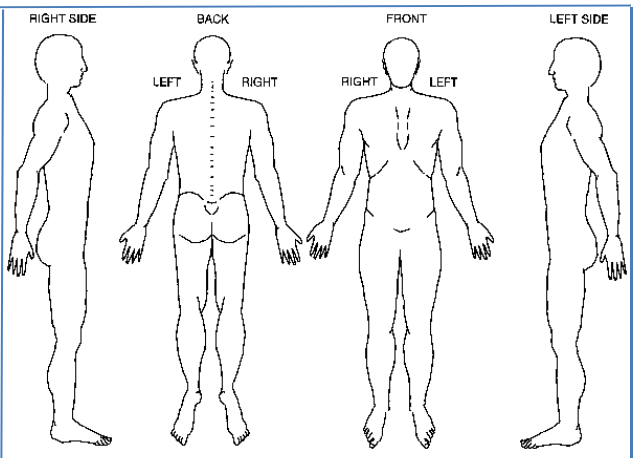
and assign directly Christine Harrison, LMT all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If the

account balance goes to collections, I understand that I am responsible for any and all collection fees. I hereby auth Christine Harrison, LMT to release all information necessary to secure payments from insurance I authorize the use of this signature on all insurance and claim and if the account balance goes to collections.

Responsible Party Signature: _____
Relationship: _____ Date: _____

Patient Condition:

Reason for visit: _____
When did you symptoms appear: _____
Is this condition getting progressively worse: ☐ yes ☐ no
Rate severity of pain on a scale 1 (least) to 10 (severe): _____
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Ache ☐ Stiffness ☐ Burning ☐ Cramps ☐ Shooting
☐ Swelling ☐ Tingling ☐ Other: _____
How often do you have pain: _____
Is it consistent or does it come and go: _____
Are you working: ☐ yes ☐ no
Does it interfere with: ☐ work ☐ sleep ☐ daily life ☐ recreation
Activities or movements that are painful: ☐ sitting ☐ standing
☐ walking ☐ bending ☐ lying down ☐ kneeling



Shade in the area(s) on the picture where you continue to have pain, numbness or tingling.

☐ Check if not workers compensation or no-fault

Accident Information

Is this condition due to a: ☐ No-fault ☐ workers compensation if yes date of injury: _____
Do you have an attorney: ☐ yes ☐ no if yes whom, _____ Phone: _____

If no-fault Name of Insurance: _____
Address: _____
City: _____ ST: _____ Zip: _____
Phone: _____

If workers comp Name of carrier: _____
Address: _____
City: _____ST: _____ Zip: _____
Phone: _____

Name of Insurance#: _____ Address: _____

Other information you would like us to be aware of before your massage: _____
_____
_____
_____