

# 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?

- |   |   |   |                                |
|---|---|---|--------------------------------|
| <input type="checkbox"/> AUTO INSURANCE:          | <input type="checkbox"/> WORKERS' COMPENSATION: | <input type="checkbox"/> MAJOR MEDICAL: | <input type="checkbox"/> CASH: |
| <input type="checkbox"/> ATTORNEY LIEN:           | <input type="checkbox"/> CREDIT CARD:           | <input type="checkbox"/> CHECK:         |                                |
| <input type="checkbox"/> OTHER: _____             |   |   |                                |
| <input type="checkbox"/> 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: \_\_\_\_\_

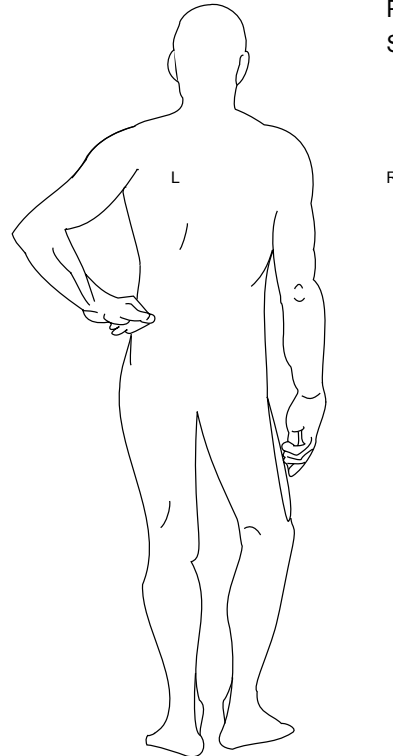
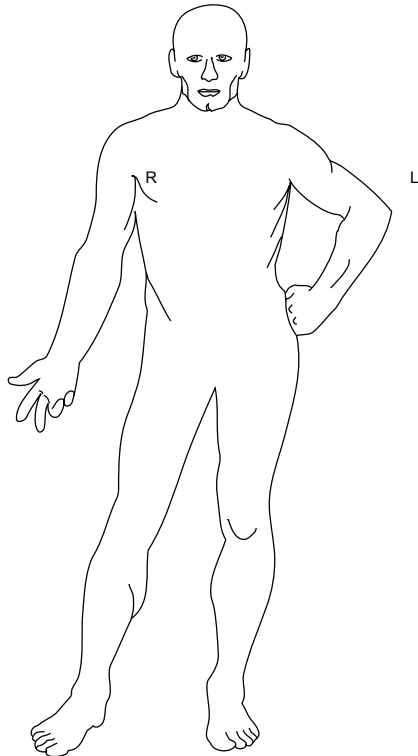
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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?

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

