

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: _____

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 be 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."

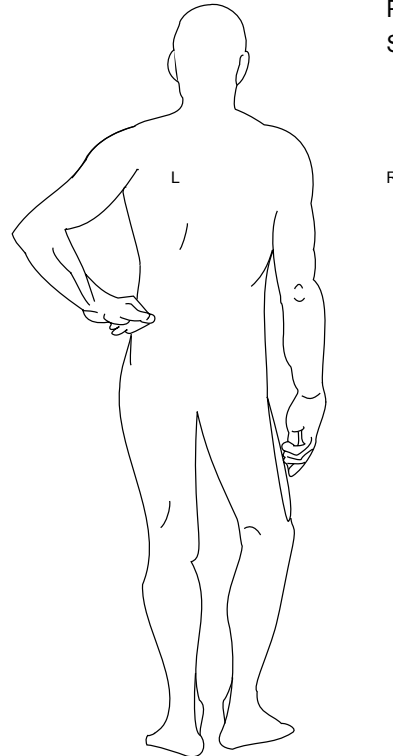
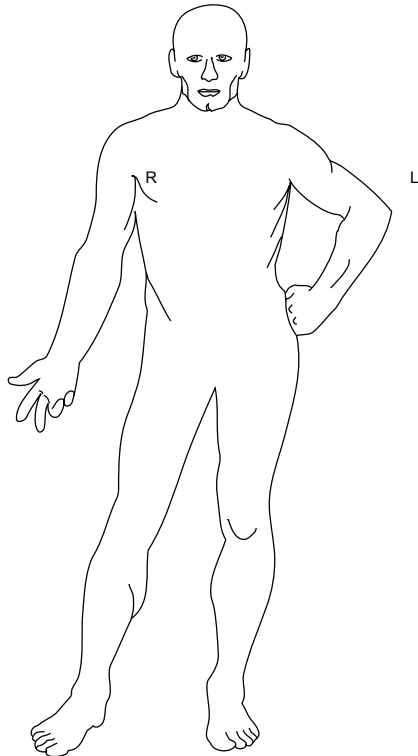
Signed: _____ Date: _____

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: _____

