DEEP TISSUE SPOKANE
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CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

FIRST NAME_____ M.I._____ LAST NAME_____
ADDRESS_____ CITY_____ STATE/ZIP_____
PHONE(H) _____ (W) _____ (C)_____DATE OF BIRTH*_____
EMAIL ADDRESS _____ REFERRED BY_____
IN CASE OF EMERGENCY CONTACT _____PHONE_____
RELATIONSHIP _____EMPLOYER/OCCUPATION_____
IS IT APPROPRIATE TO CONTACT YOU REGARDING YOUR MASSAGE AT THE ABOVE NUMBERS? Y__N__
**For birthday specials only*

MASSAGE EXPERIENCE

1st PROFESSIONAL MASSAGE? Y__N__ IF NO, HOW FREQUENTLY DO YOU GET A MASSAGE?_____
WHAT DO YOU HOPE TO ACCOMPLISH FROM TODAY'S MASSAGE?_____
_____
ARE YOU AWARE OF ANY TENSION IN YOUR BODY? Y__N__ IF YES, LOCATION(S):_____
_____

MEDICAL HISTORY

DESCRIBE ANY SURGERIES, HOSPITILIZATIONS, ACCIDENTS OR INJURIES YOU HAVE HAD:
LESS THAN 5 YEARS AGO:_____
MORE THAN 5 YEARS AGO:_____
WHAT KIND OF CARE DID YOU RECEIVE FOR YOUR ACCIDENTS OR INJURIES?_____
_____
DO YOU FEEL YOU HAVE RECOVERED FROM THESE EVENTS? Y__N__ IF NO, PLEASE EXPLAIN:____
_____
_____

MEDICAL PROVIDER INFORMATION

ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **PHYSICIAN**? Y__N__
IF SO, WHEN? _____ WHO?_____
PLEASE LIST REASON(S):_____
ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **CHIROPRACOTR**? Y__N__
IF SO, WHEN? _____ WHO?_____
PLEASE LIST REASON(S):_____

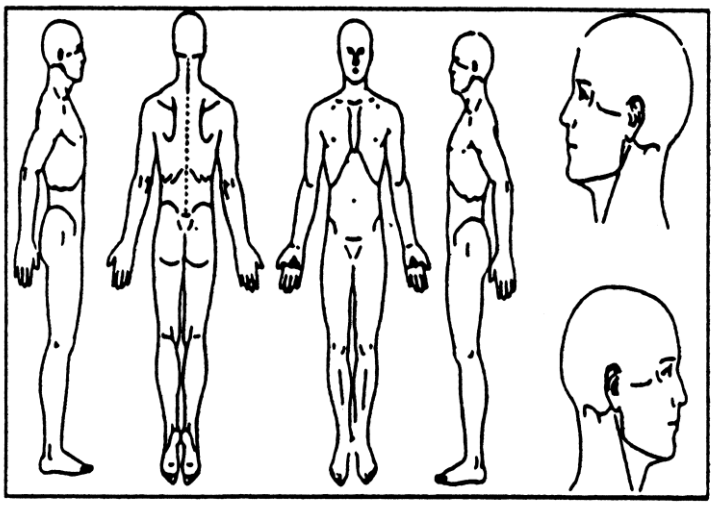
MEDICATIONS

PLEASE LIST ANY MEDICATION (VITAMINS, HERBS OR PHARMACEUTICALS) TAKEN NOW OR AT REGULAR INTERVALS:_____
_____
(INCLUDE INFORMATION OF WHAT MEDICATION IS USED TO TREAT):_____
_____

CURRENT MEDICAL COMPLAINTS/CONDITIONS

DO YOU SMOKE? Y__N__ DO YOU HAVE ANY CHRONIC, ONGOING PAIN THAT YOU DEAL WITH ON A REGULAR BASIS?_____
DESCRIBE WHAT ACTIVITIES CAUSE THIS PAIN AND/OR MAKE IT WORSE?_____
_____
ARE YOU RECEIVING ANY OTHER TYPE OF MEDICAL TREATMENT? Y__N__ PLEASE EXPLAIN:_____
_____
ARE THERE ANY OTHER HEALTH CONCERNS YOU WISH TO DISCUSS TODAY? Y__N__ IF YES, PLEASE DESCRIBE_____

PLEASE SHADE IN WHERE YOU EXPERIENCE PAIN ON THE DRAWING BELOW



ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?

___PREGNANCY ___FLU OR COLD ___INFLAMMATION ___FEVER ___INFECTION ___CONTAGIOUS DISEASE

PLEASE ANNOTATE ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY AFFECT YOU OR THAT YOU HAVE EXPERIENCED IN THE LAST 5 YEARS:

Are you having any MUSCULOSKELETAL (muscle/skeletal) conditions/diagnosis'/problems?

_____

_____

Are you having any RESPIRATORY conditions/diagnosis'/problems?

_____

_____

Are you having any CIRCULATORY conditions/diagnosis'/problems?

_____

_____

Are you having any DIGESTIVE conditions/diagnosis'/problems?

_____

_____

Are you having any SKIN conditions/diagnosis'/problems?

_____

_____

Are you having any NERVOUS SYSTEM conditions/diagnosis'/problems?

_____

_____

Are you having any OTHER conditions/diagnosis'/problems?

_____

_____

THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MASSAGE THERAPISTS DO NOT DIAGNOSE DISEASE, PRESCRIBE MEDICATIONS OR MANIPULATE BONES. I FURTHER UNDERSTAND THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION OR EXAMINATION. I TAKE RESPONSIBILITY FOR ALERTING MY PRACTITIONER TO ANY PHYSICAL, MENTAL OR EMOTIONAL CHANGES THAT OCCUR WITH MY HEALTH. ***I ALSO UNDERSTAND THAT CANCELLED OR MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE (MEDICAL or FAMILY EMERGENCIES or ILLNESSES EXCLUDED) WILL RESULT IN $60.00 CHARGE TOWARDS MY ACCOUNT.***

SIGNATURE_____**DATE**_____

Disclosures and agreements

1. Information Release – I authorize the release of any medical information necessary to process this claim. Initials _____
2. Contract for Care: I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my therapist any time I feel my well-being is threatened or compromised. I expect my therapist to provide safe and effective treatment. Initials _____
3. Services Agreement – All insurance policies, even for automobile injuries, are a contract between the insurance company and the patient. I am willing to bill your insurance company for you, but you are responsible for all payments on your account. Initials _____
4. Payment Authorization - I authorize payment of medical benefits to my massage therapist for services rendered. Initials _____

If the below does not pertain to you, disregard:

5. Motor Vehicle Accident Patients: To ensure payment will be met for services rendered, a lien may be filed – once an attorney becomes involved. The lien will be against the insurance company responsible for payment, the at-fault-driver and the patient, respectively. The charge for filing the lien is $105 and responsibility for payment is in the order mentioned in the previous sentence. Initials _____

a. Please answer the following question to ensure accurate filing information:
1. Location of accident, city, state:_____
2. Date of accident: _____
3. Name of at-fault driver:_____
b. Address of at-fault driver:_____

REFERRAL INCENTIVE:

For every person who comes in based off your referral, you will receive $30 credit towards your account. Initials _____

Cash Fees:		**Discount Massage Packages:**	
1 Hour	$65	5-1 Hour	$265
1 ½ Hour	$90	3-1 Hour	$165
		5-1 1/2 Hour	$415
		3-1 1/2 Hour	$255