DEEP TISSUE SPOKANE ***RENNAE SCHMIDT, LICENSED MASSAGE PRACTITIONER***

112 N UNIVERSITY RD., #106, SPOKANE VALLEY, WA 99206 - BLDG B ***OFFICE: 509-280-6720***
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CLIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

FIRST NAME_____ M.I._____LAST_____
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, HOSPITALIZATIONS, ACCIDENTS OR INJURIES YOU HAD: LESS 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 REASONS_____
_____

ARE YOU CURRENTLY/OR HAVE BEEN UNDER THE CARE OF A **CHIROPRACTOR**? 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):_____
_____
_____

DO YOU SMOKE? Y__N__

CURRENT MEDICAL COMPLAINTS/CONDITIONS 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?_____

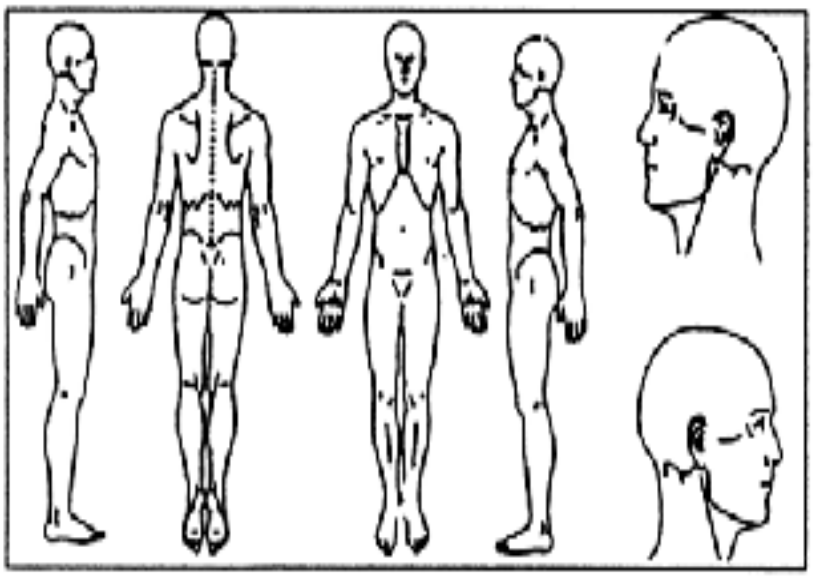
_____

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



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 WILL RESULT IN $65.00 CHARGE TOWARDS MY ACCOUNT. (MEDICAL or FAMILY EMERGENCIES or ILLNESSES EXCLUDED)***

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 _____

REFERRAL INCENTIVE:

For every person who comes in based off your referral, you will receive $32.50 credit towards your account. Initials _____