Medical History and Information

2600 SW Barton Street
Westwood Village Suite A24
Seattle WA 98126
Phone: 206-453-5397
Fax: 206-453-5630
WestSeattleWellness.com

Confidential Health Intake Form

Name_____ Date of Birth _____

Street Address_____City_____State_____Zip_____Work Ph: _____

Home Ph: _____Cell/Other_____

Emergency Contact Name:_____Cell/Other_____

Email address for appt. confirmations: _____

Email address for billing purposes (must be valid): _____

How did you hear about us? _____

Employer_____Occupation_____

If we are billing your insurance – please complete the following Insurance Information:

Referring Physician:_____Primary Care Physician:_____

Was Injury a result of an accident?_____If yes: Job related_____Auto_____Other_____

Date of Injury or onset: _____

*A copy of your insurance card is required for West Seattle Wellness to bill your insurance. Please provide a copy of card.

Insurance Company Name: _____

Billing Address: _____

Contact person/ case manager _____Phone Number: _____

Name of Insured: _____

Address:_____

Phone: _____

Group/Claim Number/ID number: _____

Attorney (*if applicable*): Name: _____

Address:_____

Phone number: _____

- I hereby authorize the release of my medical records and personal information to all insurance companies named above for the express purpose of
- payment for my medical bills incurred in this office, for the current incident above. I hereby authorize West Seattle Wellness, and any affiliate billing agent, to release any personal and health information necessary to my insurance and to process claims on my behalf. Under State and/or Federal guidelines, certain diagnoses and treatment may not be released without specific authorization. I understand that West Seattle Wellness will not release information concerning drug/alcohol abuse or treatment, psychiatric treatment, or HIV testing and or treatment without prior written consent. I hereby authorize the above-named insurance company or attorney to remit payment directly to this office on my behalf.
- I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.
- I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any
- questions or concerns immediately.
- I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
- **I agree to provide 24-hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee. (Please note that insurance companies do not pay this, you do.)**

Medical History and Information

Check any or all that apply to your present health:

___ headaches	___chronic pain	___varicose veins
___ vision problems	___muscle or joint pain	___blood clots
___ sinus problems	___numbness/tingling	___high/low blood pressure
___ jaw pain/teeth grinding	___sprains/strains	___diabetes
___ fatigue	___scoliosis	___cancer/tumors
___depression	___arthritis	___infectious disease
___ sleep difficulties	___tendonitis	___skin problems

Women only: ___Pregnant ___ Painful menstruation ___ endometriosis

Men only: ___Prostrate problems

For massage therapy treatment purposes, please check ALL areas that you give your permission to be undraped:

___back ___ glutes/hips ___legs ___arms ___abdomen ___chest

List all medications/herbs/vitamins and dosage:

_____

List physical activities you participate in regularly_____

What movements or activities are limited? _____

Describe the events of the injury or accident:

_____

_____

List previous major injuries/surgeries:

_____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic):

_____

_____

What seems to help the most? _____

What seems to aggravate the condition the most?_____

What is your main activity at work? On phone_____Sitting_____Computer work_____

Driving a car_____Walking____Other

What do you do to relieve stress? _____

What do you want to get out of your session (s)? _____

Practitioner Comments

_____

_____

Signature_____Date _____

Client Name: _____Date _____