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www.thehealthandwellnessclinic.com

the Health & Wellness clinic

PATIENT INTAKE FORM
PLEASE FILL OUT BOTH SIDES

PATIENT INFORMATION

Last Name Of Patient	First Name	MI	❒ Male ❒ Female	Age

Address	City	State	Zip

Home Phone	Work/Cell Phone	Date Of Birth	Social Security No.	Employer	Years
( )	( )				

Employer's Address	City	State	Zip	Who Will Be Paying The Bill ❒ Self ❒ Other	❒ Married ❒ Single

PARENT OR GUARDIAN INFORMATION

Last Name Of Responsible Party	First Name	MI	❒ Male ❒ Female

Address (❒ Same As Patient)	City	State	Zip

Home Phone	Work/Cell Phone	Date Of Birth	Social Security No.	Employer	Years
( )	( )				

Employer's Address	City	State	Zip	Relationship To Patient

EMERGENCY CONTACT

Last Name	First Name	Phone	Address
		( )	

MEDICAL INSURANCE INFORMATION

Name Of Primary Insurance Company	Group #	Id #	Phone
			( )

Address	City	State	Zip

Name Of Insured (❒ Same As Patient) - **For L & I And Auto, Please Fill Out Section Below**

Address Of Insured (❒ Same As Patient)

Patient's Relationship To Insured

❒ Self ❒ Husband ❒ Wife ❒ Child ❒ Domestic Partner ❒ Other

L & I / AUTO {PIP} INSURANCE INFORMATION

Insurance Plan

Name Of Policy Holder

Billing Address	City	State	Zip

Member Id #	Group #

Claim #	Date Of Injury	Adjuster

REASON FOR YOUR VISIT

Who may we thank for referring you to our clinic

MEDICAL HISTORY

- ❒ High Blood Pressure
- ❒ Osteoporosis
- ❒ Pregnancy
- ❒ Varicose Veins
- ❒ Sports Injury
- ❒ SLE/Lupus
- ❒ Ulcerated Colon
- ❒ Regular Exercise/Sports
- ❒ Heart Ailment
- ❒ Neck/Spine Injury
- ❒ Cold/Flu Virus
- ❒ Phlebitis
- ❒ Acute/Chronic Pain
- ❒ Cancer
- ❒ Skin Disorder
- ❒ Other _____
- ❒ Headaches
- ❒ On Daily Medication
- ❒ Diabetes
- ❒ Scoliosis
- ❒ Arthritis
- ❒ Kidney Ailment
- ❒ Current Rashes/Lice, etc.
- ❒ Impaired Vision/Contacts
- ❒ High Cholesterol
- ❒ Sciatica
- ❒ AIDS
- ❒ Asthma/Allergies
- ❒ Tendonitis
- ❒ High Blood Pressure

List Any Allergies You Have (Include food and medication)

List Any Surgeries, Hospitalizations or Major Injuries You Have Had - **Include Dates**

List Any Chronic Medical Conditions You Currently Have

List Any Medications/Supplements You Are Currently Taking

PAYMENT POLICIES/MEDICAL RELEASE

Insurance Billing/Payment

The Health & Wellness clinic will bill my insurance company, as long as I've provided all necessary paperwork to do so, and the benefits my plan permits. I agree that all payments from my insurance company will be paid directly to The Health & Wellness Clinic. I understand that I am responsible for any unpaid treatments or balance due in excess of 60 days, regardless of my insurance coverage.

I agree _____

15 Min. Policy

I understand that if I am 15 min. or later to my scheduled appointment, it is at the practitioner's discretion that I be seen. This is to ensure that other scheduled appointments are not disrupted. Please call the office if you will be late to an appointment.

I agree _____

No Show

A $50.00 fee will be collected for failure to show up to a scheduled appointment, or cancelling with less than a 48 hour notice. This fee must be paid in full before the next appointment.

I agree _____

Credit Card Policy

A credit card number is retained at the booking of patient's initial visit. In the event of a missed appointment, the credit card will be charged the "No Show" fee, unless settled otherwise. The card number provided will be held in a secure place and used for no other reason than that given above.

I agree _____

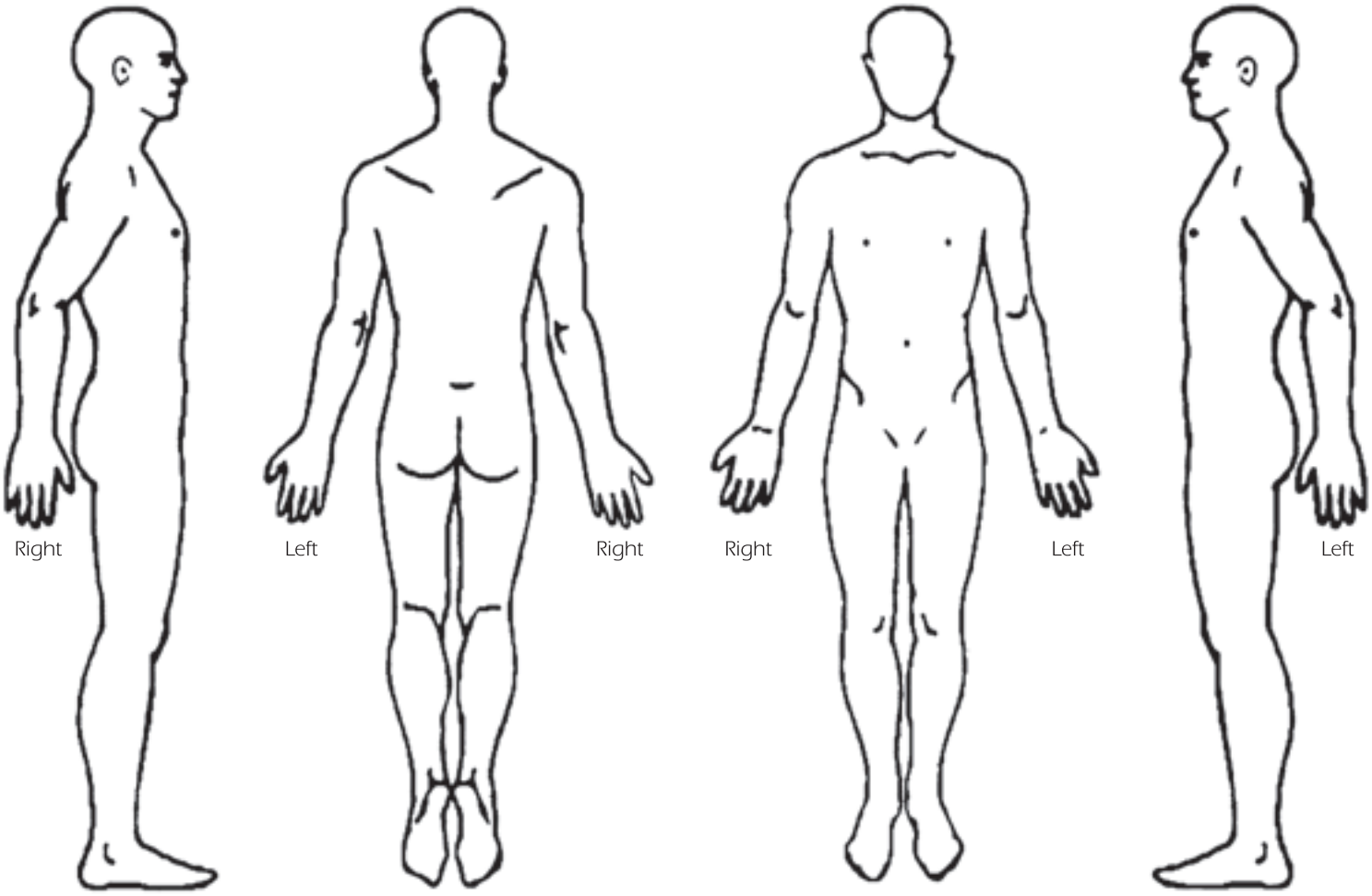
Medical Release Authorization

I authorize my massage therapist, insurance company, healthcare provider, hospital, and employer to release information or confer in the interest of my current claim. I agree that all information I have provided is true, and that it is illegal to omit or falsify any part of this form.

I agree _____

Signature of Patient/Guardian _____ **Date** _____

DRAW ANY SYMPTOMS YOU ARE EXPERIENCING ON THE FIGURES BELOW



CIRCLE THE INTENSITY OF YOUR SYMPTOMS

NO PAIN	1	2	3	4	5	6	7	8	9	10	UNBEARABLE PAIN

DESCRIBE ANY MARKINGS MADE ON FIGURES ABOVE

Patient Signature _____ Date _____