Phone # 253.850.2800
Fax # 253.850.2805

Evergreen Massage Therapy

www.evergreenmassagetherapy.com

1048 West James Street, Ste 104
Kent, WA 98032

CONFIDENTIAL PATIENT INFORMATION: **DATE:**

Name: (Last, First) Date of Birth:

Address:

Email Address:

Home Phone Mobile/Work Phone

Spouse/Emergency Contact & Phone #

Please Circle One: Health Insurance Self Pay
Auto Accident L & I / Workers Comp

Insurance I.D.# or Claim/L&I #

Insurance Provider:

Insurance Card/Copy Provided? Yes / No

Relation to the insured:

Claims Adjuster Contact:

Are you currently seeing a doctor? Yes / No

Were you referred to us? No / Yes: by whom

Have you had Massage before Yes / No Date of Last Massage:

History: *Circle ALL that apply* Dizziness Head Aches TMJ Diabetes Eczyma Hives/Rash

Asthma Carpal tunnel Fibromyalgia Thoracic Outlet Syndrome Numbness Anywhere? Y / N

HBP / LBP Heart Disease Depression Poor Circulation Arthritis: Where?

Contacts? Y / N

Allergies:

Pregnant? Y / N

Medications:

Do you have or have you had cancer? NO / YES: When? What type?

Surgeries/Injuries:

Describe Accident/Work Injury: Date of Injury:

What is your Primary Complaint:

What is your Secondary Complaint:

Other complaints:

How would you describe your Activities of Daily Living? *Circle all that apply* Low Activity High Activity
Low Stress High Stress Relaxed Intense Low Impact High Impact Highly Repetitive

How many hours do you spend at a computer per day? Number of hours in a vehicle?

I understand massage practitioners do not diagnose illness, disease, or other physical or mental disorders. Massage is not a substitute for a medical examination or diagnosis and that I should see a physician for any medical questions and concerns I may have. I have stated all known medical conditions and take it upon myself to keep the practitioner updated on any changes in my health. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefit program to release information to you regarding my coverage. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefit program identified above to obtain payment for care, treatment, supplies and other services.
The above information is true to the best of my knowledge.

Date: **Signature:**