



# Monroe Wellbeing Massage

at the

Wellbeing Center for Health

TYCS

## Intake Form

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Birthdate \_\_\_\_\_ M  F  Occupation \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Hobbies \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Dr Phone # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

In case of an emergency, please contact \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_

Insured's Phone \_\_\_\_\_ Insured's SS# \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Your relationship to insured  Self  Spouse/Partner  Child

Insured's Sex  Female  Male Insured's Employer or School \_\_\_\_\_

In order to bill your private health company, we must have a copy of your insurance card.

### ***Please read and sign below***

I understand that massage is given at Monroe Wellbeing Massage for the purpose of stress reduction; relief from muscular tension, spasm, or pain; or for further increasing circulation and/or general well being. I further understand that the massage practitioner does not diagnose illness, disease, or any other physical or mental disorder nor prescribe medical treatment or medicines. I agree to see a physician for any physical or mental ailment that I might have. I have stated all known medical conditions (see back of form) and agree to inform the massage practitioner of any changes in my physical or mental health.

Payment is due at the time of service. Once your insurance coverage has been verified, PIP and personal insurance accounts may be billed directly to the insurance company; however, your account is due in full within 60 days regardless of insurance coverage. Finance charges of 1.5% per month will be assessed thereafter. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. You, the patient/parent/guardian, agree to pay all collection costs including, but not limited to reasonable attorney fees, late charges, and litigation costs in the event of any breach, including failure to make timely payments.

Missed appointments, or those cancelled with less than 24 hours notice, will be billed at standard rate.

I authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office. I authorize the insurance company or attorney to remit payment directly to this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Patient / Parent / Guardian)

In fairness to us and our other patients, a 24 hour notice is required for cancellation of an appointment.

(OVER)

## Current Health

Are you currently receiving treatment by a health care provider? Yes  No

If yes, list the conditions you are being treated for \_\_\_\_\_

Health care provider's name \_\_\_\_\_ Phone \_\_\_\_\_

May I have permission to contact your health care provider? Yes  No

List medications you are taking (include aspirin, ibuprofen, etc.) \_\_\_\_\_






In your opinion, what are your most important health concerns? \_\_\_\_\_

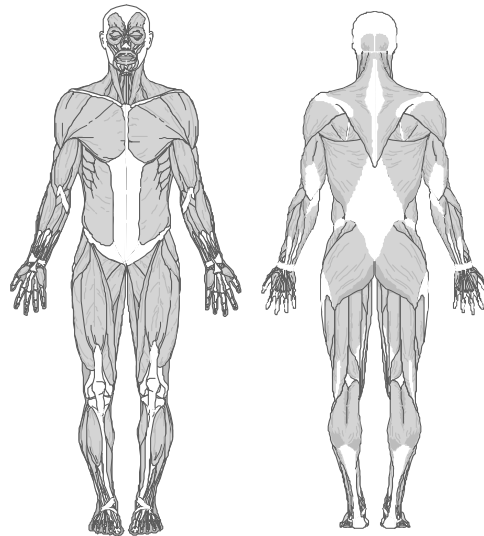
Do you currently have any of the following conditions? (please check)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Asthma/Allergies   | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Whiplash            | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Head Aches         | <input type="checkbox"/> Kidney Ailment       | <input type="checkbox"/> Sinus               | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Jaw Pain/TMJ       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Cardiac Conditions  | <input type="checkbox"/> Cold/Flu             |
| <input type="checkbox"/> Emotional Changes  | <input type="checkbox"/> Varicose Veins       | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Aids/HIV             |
| <input type="checkbox"/> Grief Process      | <input type="checkbox"/> Tendonitis/Bursitis  | <input type="checkbox"/> Sports Injury       | <input type="checkbox"/> Sleep Disorder       |
| <input type="checkbox"/> Osteoarthritis     | <input type="checkbox"/> Fever                | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Skin Disorder        |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Muscular Dystrophy   | _____  | _____   |

- ♀  Pregnancy       PMS       Menstruation       Menopause

Mark the diagrams using the following symbols

<p><b>Pain Scale</b></p> <p>10 = Worst possible pain</p> <p>9 = Very severe pain</p> <p>8</p> <p>7 = Severe pain</p> <p>6</p> <p>5 = Moderate pain</p> <p>4</p> <p>3 = Mild pain</p> <p>2</p> <p>1 = Slight pain</p> <p>0 = No pain</p>	<p>Pain </p> <p>Spasm </p> <p>Tension </p> <p>Surgery </p> <p>Injuries </p>
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## Medical History

Surgeries \_\_\_\_\_

Accidents \_\_\_\_\_

## Massage History

Have you ever received a professional massage? Yes  No