



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 _____ Please email news and specials

Birth Date _____ M F Occupation _____

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% 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)

- Asthma/Allergies
- Head Aches
- Jaw Pain/TMJ
- Emotional Changes
- Grief Process
- Osteoarthritis
- Cancer
- Multiple Sclerosis

- Elevated Cholesterol
- Kidney Ailment
- Diabetes
- Varicose Veins
- Tendonitis/Bursitis
- Fever
- Low Blood Pressure
- Muscular Dystrophy

- Whiplash
- Sinus
- Cardiac Conditions
- Scoliosis
- Sports Injury
- High Blood Pressure
- Osteoporosis

- Fatigue
- Constipation
- Cold/Flu
- Aids/HIV
- Sleep Disorder
- Rheumatoid Arthritis
- Skin Disorder

Pregnancy

PMS

Menstruation

Menopause

Mark the diagrams using the following symbols

Pain Scale

10 = Worst possible pain

9 = Very severe pain

8

7 = Severe pain

6

5 = Moderate pain

4

3 = Mild pain

2

1 = Slight pain

0 = No pain

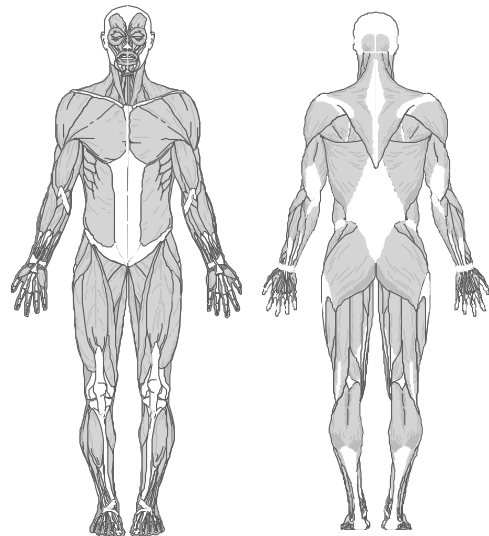
Pain

Spasm

Tension

Surgery

Injuries



Medical History

Surgeries _____

Accidents _____

Massage History

Have you ever received a professional massage? Yes No