MARGARET M. MAGEE, DBA MASSAGE FOR LIFE

MASSAGE FOR LIFE

P.O. Box 997 – Bethpage, NY 11714

516.330.9817

massageforlife2@gmail.com

Medical History Intake Form

If this is an injury, is it from an auto accident? **YES** **NO** *(circle one)*

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ Middle Initial: _____

Mailing Address: ___________________________________City: __________________ State: ____ Zip: ___________

Phone Number: Home _______________________Cell ________________________ Work ______________________

Date of Birth: _________________ Gender: M F Marital Status: S M D W Email address: ____________________

EMERGENCY CONTACT

Last Name: ____________________ First Name: ____________________

Relationship to Patient: ____________________ Phone Number: _________________________

PATIENT EMPLOYER INFORMATION

Name of Company: _________________________ Phone Number: _________________________

Mailing Address: ___________________________________City: __________________ State: ____ Zip: ___________

RESPONSIBLE PARTY INFORMATION (if different from above):

Last Name: ____________________ First Name: ____________________ Middle Initial: _____

Mailing Address: ___________________________________City: __________________ State: ____ Zip: ___________

Phone Number: Home _______________________Cell ________________________ Work ______________________

Date of Birth: ____________ Gender: M F Marital Status: S M D W Email address: _________________________

Relationship to Patient: ____________________

INSURANCE POLICY HOLDER INFORMATION

Primary

Insurance: ____________________ Subscriber ID#: ____________________ Group#: ____________________

Last Name: ____________________ First Name: ____________________ Middle Initial: _____

Date of Birth: _________________________ Gender: M F Marital Status: S M D W

Relationship to Patient: ____________________

Secondary

Insurance: ____________________ Subscriber ID#: ____________________ Group#: ____________________

Last Name: ____________________ First Name: ____________________ Middle Initial: _____

Date of Birth: _________________________ Gender: M F Marital Status: S M D W

Relationship to Patient: ____________________

Reason for consulting us:____

Have you received a massage before: Yes____No____(*if yes, how often)*__________________

Do you have allergies to: *(circle all that apply)*

latex creams oils essential oils *(if yes, what kind)*_______________

other___________________________

What medications do you take:____

Do you have a history of any of the following? *(circle all that apply)*

abdominal pain	disk problems	neck pain	stiffness
accident	gastric tube	nervous tension	stroke
arthritis	heart attack	osteoporosis	varicose veins
behavior disorder	headaches	pacemaker	visual impairment
broken bones	high BP	scoliosis	whiplash
cancer	joint ache	seizures	
decreased ROM	low back pain	sexual abuse	
diabetes	mid back pain	sprains/strains	

Anything else we should know?

____

____

PLEASE NOTE: All PHI (Protected Health Information) is privileged and confidential. The information provided shall be used for the individual or entity named. Any other use is violation of Federal Law and will be reported as such.

I authorize the release of information including the diagnosis, records, examinations, and claims information, to be left on my voice mail. This Release of Information shall remain in effect until terminated by me, in writing. This information may be disclosed to employees, agents, and officers of MARGARET M. MAGEE, DBA Massage For Life. I further authorize this information to be released to:

Spouse _____________________________ Phone _____________________________

Child _____________________________ Phone _____________________________

Doctor _____________________________ Phone _____________________________

Other _____________________________ Phone _____________________________

OR: (*initial here*) ___ My information is not to be released to anyone, except me.

How did you hear about us: (circle all that apply)

Family	newspaper	mail out / flyer	television	employee
Internet	drive by	billboard / sign	friend	referring physician
walk in	yellow pages	referred by employer	patient	school nurse

I certify that all the information provided above is complete and accurate.

____________________ __________________

Signature of Patient Date