MARGARET M. MAGEE, DBA MASSAGE FOR LIFE

MASSAGE FOR LIFE

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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