

**Eric Watts, LMP • Muscular Support Therapy**

615 SE Chkalov Dr, Suite 7 Vancouver, WA 98683

(360) 909-1520 www.muscularsupport.com

Date \_\_\_\_\_ Referred By \_\_\_\_\_

**CONFIDENTIAL CLIENT INFORMATION** (Please Print)

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_-\_\_\_\_-\_\_\_\_

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

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: (please circle) SINGLE MARRIED WIDOWED How did you hear about me? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_ Date Symptoms Began \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Surgeries, Major Illnesses, Hospitalizations and Major Accidents (include dates) \_\_\_\_\_

List all conditions currently monitored by a Health Care Provider \_\_\_\_\_

**List Health/Concerns & Check all that apply**

**Primary** \_\_\_\_\_  mild  moderate  disabling  constant  intermittent

*My symptoms:*  increase w/ activity  decrease w/ activity  getting worse  getting better  no change

**Secondary** \_\_\_\_\_  mild  moderate  disabling  constant  intermittent

*My symptoms:*  increase w/ activity  decrease w/ activity  getting worse  getting better  no change

**Additional** \_\_\_\_\_  mild  moderate  disabling  constant  intermittent

*My symptoms:*  increase w/ activity  decrease w/ activity  getting worse  getting better  no change

**Treatment received** \_\_\_\_\_

**INSURANCE INFORMATION** (if applicable)

Relationship to Insured? (Please circle) SELF SPOUSE OTHER CHILD SPOUSE \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Claims Address \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ ID/SSN \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Deductible Amount \$ \_\_\_\_\_ Percent of Coverage after Deductible \_\_\_\_\_ Co-payment Required \$ \_\_\_\_\_

**SIGNATURE ON FILE:** I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. In the event that my insurance does not pay for products and services rendered, I understand that I am personally responsible for payment immediately.

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

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

General

current past comments
headaches
pain
sleep disturbances
fatigue
fever
sinus
other

Skin Conditions

current past comments
rashes
athlete's foot, warts
other

Allergies

current past comments
scents, oils lotions
detergents
other

Muscles and Joints

current past comments
rheumatoid arthritis
osteoarthritis
osteoporosis
scoliosis
broken bones
spinal problems
disk problems
lupus
TMJ, jaw pain
spasms, cramps
sprains, strains
tendonitis, bursitis
stiff or painful joints

current past comments
weak or sore muscles
neck, shoulder, arm pain
low back, hip, leg Pain
other

Nervous System

current past comments
head injuries, concussions
dizziness, ringing in the ears
loss of memory, confusion
numbness, tingling
sciatica, shooting pain
chronic pain
depression

Respiratory, Cardiovascular

current past comments
heart disease
blood clots
stroke
lymphedema
high, low blood Pressure
irregular heart beat
poor circulation
swollen ankles
varicose veins
chest pain, shortness of breath
asthma

Digestive/Elimination System

current past comments
bowel dysfunction
gas, bloating
bladder/kidney dysfunction
abdominal pain
other

Endocrine System

current past comments
thyroid dysfunction
diabetes

Reproductive System

current past comments
pregnancy
painful, emotional menses
fibrotic cysts

Cancer/Tumors

current past comments
benign
malignant

Habits

current past comments
tobacco
alcohol
drugs
coffee, soda

\*Please list any Medications/Herbs/Supplements you are currently taking and the reason:

Table with 4 columns: Medications, Reason, Medications, Reason. Includes horizontal lines for text entry.

Consent for Care: It is my choice to receive Massage Therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

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

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_