

Eric Watts, LMP • Muscular Support Therapy

14313 NE 20th Ave, Suite A112 Vancouver, WA 98686

(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 _____