Evergreen Massage Clinic

410 South Spruce Street, Burlington (360) 941-7663
MAILING ADDRESS: P.O. Box 2683, Bellingham, WA 98227-2683
Email: kristi@evergreenmassageclinic.com Fax: 360-671-6586

CONFIDENTIAL CLIENT INTAKE FORM

PERSONAL

Date:_____

Name:_____

Address:_____

_____

Phone: (H) _____ (W) _____

Cell Phone: _____

Email: _____

May I email a few times a year? yes _____ no_____

Employer: _____

Date of Birth: _____

Referred by: _____

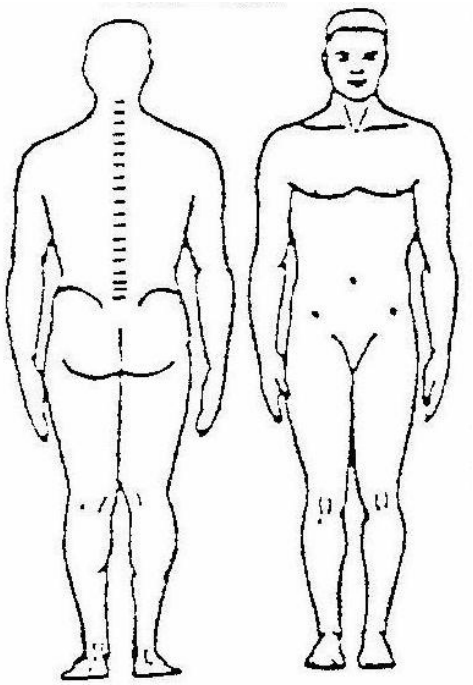
Emergency Contact: _____

Phone: _____

Is this your first massage? ☐ Yes ☐ No

Please check any of the following which currently apply

- ☐ Wearing contact lenses
- ☐ Localized Infection
- ☐ Acute Inflammation
- ☐ Pregnant
- ☐ Fever
- ☐ Communicable disease



In the above figure please identify with an X the areas where you are experiencing tension or discomfort.

Reason for Massage: _____

_____

Goals / Intention for Massage: _____

_____

INSURANCE

Insurance Company: _____ Claim #: _____

Address: _____

Adjuster: _____ Phone #: _____

Date of Injury: _____ Referring Doctor: _____

Employer when Injured: _____

Other parties Insurance Co: _____

Address: _____

Attorney: _____Phone: _____

Address: _____

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CONFIDENTIAL CLIENT INTAKE FORM (Page 2)

HEALTH HISTORY

Please list the name and occupation of any health care practitioners you have seen in the past year. Name, Occupation:

_____

_____

Previous Treatments/Therapies (please include any personal treatments i.e. diet, yoga, exercise): _____

_____

Please List any medication you are taking including aspirin and for what ailment: _____

_____

Have you experienced any of the following conditions?

- ☐ AIDS
- ☐ Allergies/Hay fever
- ☐ Arthritis/Gout
- ☐ Bursitis/Joint Disorder
- ☐ Cancer/Tumors
- ☐ Circulation Problems
- ☐ Colitis/Diverticulitis
- ☐ Constipation/Diarrhea
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Disc Problems
- ☐ Epilepsy/Seizures
- ☐ Headaches/Migraines
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ High/Low Blood Pressure
- ☐ Menstrual/Ovarian Problems
- ☐ Muscle Spasms
- ☐ Numbness/Tingling
- ☐ Phlebitis
- ☐ Psoriasis
- ☐ Sciatica
- ☐ Skin Disorders
- ☐ Strains/Sprains
- ☐ Excess Stress
- ☐ Swollen Feet/legs
- ☐ Tendonitis
- ☐ Thrombosis/Embolism
- ☐ Varicose Veins
- ☐ Drug Addition

Comments: _____

_____

_____

PLEASE READ AND SIGN THE FOLLOWING:

The above information is accurate and true to the best of my knowledge. I agree to the release of information for medical or insurance purposes. I authorize Evergreen Massage Clinic and Kristine Allen, LMP, to obtain information from my primary health care providers concerning my health.

I agree to pay all collection cost including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments. Any account 30 days past due will be charged a 1% interest monthly, 12% annually.

In fairness to our other patients and to Evergreen Massage Clinic, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Signature: _____ Date: _____
(Patient/Parent/Guardian)