# *MILWAUKIE MASSAGE CLINIC*

***5111 SE Lake Road, Milwaukie, OR 97222, Phone: 503.659.5900***

# *CONFIDENTIAL MASSAGE INTAKE FORM*

**PLEASE PRINT CLEARLY**

First Name__________________________________ Mid Initial____ Last________________________________________________

Address________________________________________________________________________________________________

City______________________________________ State________ Zip________________ Birth Date _______________________

**Work Phone_________________________ Home Phone__________________________ Cell_____________________________**

Emergency Contact__________________________________________ Phone____________________________________________

Email Address (for appoint. confirmations and newsletters)_________________________________@______________________
_______________________________________________

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**Briefly describe your reasons for coming in today___________________________________________________________________**

Are you currently under a physician's care? YES / NO If yes please specify reason and with whom: _________________________
________________________________________________________________________________________________________

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PLEASE LIST YOUR COMPLETE MEDICAL HISTORY INCLUDING:

FRACTURES/DISLOCATIONS_____________________________________________ WHEN__________________________
SURGERIES____________________________________________________________ WHEN_________________________
CANCER_______________________________________________________________ WHEN_________________________
RECENT ACCIDENTS, INJURIES OR ILLNESS___________________________________________________________
OTHER____________________________________________________________________________________________
ARE YOU TAKING ANY MEDICATIONS? YES__ NO__ WHAT KIND? ______________________________________
IS THERE ANY AREA YOU WOULD LIKE EXTRA TIME SPENT? IF YES PLEASE DESCRIBE: _______________
_________________________________________________________________________________________________
DO YOU HAVE A PREFERENCE FOR A SPECIFIC TYPE OF MASSAGE? PLEASE DESCRIBE: ______________
_________________________________________________________________________________________________

***ARE WE BILLING YOUR INSURANCE COMPANY?*** ___Yes ___No Type: _____Auto _____Health

Insurance Company____________________________________________________ ID#______________________________________

Insurance Company Address: ________________________________________________________________________________

Phone: __________________________________ Contact Person: __________________________________________________

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As a courtesy, Milwaukie Chiropractic & Massage Clinic, PC will bill my insurance company directly. I understand that I still remain financially responsible for all charges. I instruct my insurance company to pay Milwaukie Chiropractic & Massage Clinic, PC directly for all services and authorize the release of any information necessary to secure payment. I hereby authorize the release of any information acquired in the course of my treatment for billing purposes only. I certify that the above information is true and correct.

CLIENT SIGNATURE_______________________________________________________DATE__________________________

Therapist's notes________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________