Ultimate Body, Mind & Spirit LLC

Client Information

Date ____________________

SS/HIC/Patient ID# ____________________

Patient Name ____________________
Last

____
First   Middle Initial

Address ____________________

City ____________________

State ____________ Zip ____________

E-mail ____________________

Sex M / F

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Partnered

Occupation ____________________

Patient Employer/School ____________________

Employer/School Address ____________________

____

Employer/School Phone number ____________________

Spouse Name ____________________

Birthdate ____________________

Spouse's Employer ____________________

Referred By ____________________

Insurance

Who is responsible For this Account ____________________

Relationship to Client ____________________

Insurance Co. ____________________

Group/Claim# ____________________

is Client covered by additional Insurance Yes ☐ No ☐

Subscriber's Name ____________________

Birthdate ____________________ SS# ____________

Relationship to Client ____________________

Insurance Co. ____________________

Group # ____________________

Assignment of Benefits and Release

I Certify that I, and/or my dependent(s) have insurance coverage with ____________________ and assigned directly to
Name of Insurance Company (ies)

Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I Understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end w hen my current treatment plan is completed or one year from the date signed below

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Persona Representative

____________________ ____________________
Date   Relationship to Patient

Phone Numbers

Home ____________________ Cell ____________________

Best Time & Place to reach you ____________________

IN CASE OF EMERGENCY CONTACT

Name ____________________ Relationship ____________

Home ____________________ Cell ____________________

Accident Information

Is condition due to an accident? Yes ☐ No ☐ Date______

Type of accident Auto work Home Other

To whom have you made a report of your accident?

____Auto Insurance ____Employer _____Workers Comp. ____Other

Attorney Name (if Applicable) ____________________

Client Condition

when did your symptoms appear? ____________________

What treatment have you already received for your condition? (Circle all that apply)

Medication Surgery Physical Therapy Chiropractic Care None Other ____________

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other ____________

How often do you have this pain? ____________ Is it constant or does it come and go? ____________

Does it interfere with your (Circle all that apply) Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: (circle all that apply) Sitting Standing Walking Bending Lying Down

Name & Address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name ____________________ Name ____________________

Address ____________________ Address ____________________

Phone ____________________ Phone ____________________

Massage History

Have you ever received a professional massage? Yes No

Why did you come for service? Relaxation Pain Therapy Other ______________________

What results would you like to achieve? ______________________

____

Prioritize the area of your body that you wish to be massaged. Please note any areas of your body that you **prefer not to be** massaged ______________________

____

Health History

☐ Anemia	☐ Cancer	☐ Hepatitis	☐ Multiple Sclerosis	☐ Sinus Problems
☐ Anorexia	☐ Chemical Dependency	☐ Hernia	☐ Osteoporosis	☐ Stroke
☐ Appendicitis	☐ Diabetes	☐ Herniated Disk	☐ Pacemaker	☐ Tendonitis
☐ Arthritis	☐ Emphysema	☐ Herpes	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Asthma	☐ Epilepsy	☐ High Blood Pressure	☐ Pinched Nerve	☐ Tuberculosis
☐ Blood Clots	☐ Fibromyalgia	☐ HIV/AIDS	☐ Pneumonia	☐ Tumors, Growths
☐ Breathing Difficulty	☐ Fractures	☐ Jaw Pain/TMU	☐ Polio	☐ Ulcers
☐ Bursitis	☐ Glaucoma	☐ Lymphedema	☐ Prosthesis	☐ Varicose Veins
☐ Bronchitis	☐ Head Injuries	☐ Migraine Headaches	☐ Rheumatoid	☐ Whiplash
☐ Bulimia	☐ Heart Disease	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other

Medications

Medications Taking For:

____

____

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Lifestyle

☐ Smoking	Packs per day	______
☐ Alcohol	Drinks/Week	______
☐ Coffee/Caffeine	Cups/day	______
☐ High Stress Level	Reason	______

Are you pregnant Yes ☐ No ☐ Due Date ______________________

Please list any medical conditions,. Surgeries, accidents and bone, joint, nerve or muscle diseases or injuries not specified above.

______________________ Date ______________

______________________ Date ______________

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy are not qualified to diagnose, prescribe or treat and physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

______________________ ______________________
Signature or Patient, Parent, Guardian or Personal Representative Date

______________________ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient