Rise Up Therapeutic Massage

Confidential Questionnaire for Massage

Date _____

Name (First, Last, M.I.) _____

Address (with city & zip) _____

Email:_____

Phone: _____

Date of Birth: _____ Age: _____ Sex ☐ F ☐ M Marital Status ☐ S ☐ M ☐ D

*Required for insurance only: SS # _____*Driver's Licence # _____

Name of Referring Physician or how did you learn about us? _____

Your Insurance Information

Type of Insurance: ☐ Auto ☐ Health ☐ L&I/ Workers' Comp

Insurance Company _____ Name of **primary insured** _____

Primary Insured: Date of Birth _____ SS # _____ Primary is: ☐ Self ☐ Spouse ☐ Child

Primary Insured's Employer _____ ☐ Full Time ☐ Part Time

Claim # _____ Claims Adjuster _____ Phone # _____

Address _____

Please Read & Sign the Following

I acknowledge that the above information is complete and accurate to the best of my knowledge and will notify my LMP of any changes in my physical condition prior to treatment or any changes in the information on this form. I agree to the release of information for medical and/or insurance purposes and authorize Rise Up Therapeutic Massage to obtain any information from my healthcare providers concerning my health.

I am aware that I am fully responsible for all health care bills for services rendered and that payment is not contingent on any insurance payment, settlement, or judgment.

Missed appointment or cancellation with less than 24 hours notice will be charged the full amount of scheduled service.

Client Signature _____ Date _____

HEALTH HISTORY

Have you ever experienced any of the following? (mark **C** for current, **P** for past)

_____ HIV/AIDS	_____ Constipation	_____ Herpes	_____ Sciatica
_____ Allergies	_____ Diarrhea	_____ High Blood Pressure	_____ Stiff Joints
_____ Anemia	_____ Diabetes	_____ Low Blood Pressure	_____ Skin Allergies
_____ Athletes Foot	_____ Digestive Problems	_____ Insomnia	_____ Sprains/ Strains
_____ Arthritis	_____ Disc Problems	_____ Excess Stress	_____ Stroke
_____ Back Pain	_____ Diverticulitis	_____ Migraines	_____ Swollen Feet/ Legs
_____ Bone Fractures	_____ Eczema	_____ Muscle Spasms	_____ Tendonitis
_____ Bursitis	_____ Epilepsy/ Seizures	_____ Numbness	_____ Tingling
_____ Cancer	_____ Fibromyalgia	_____ Phlebitis	_____ Tumors
_____ Chronic Fatigue	_____ Headaches	_____ Psoriasis	_____ Varicose Veins
_____ Circulatory Problems	_____ Heart Attack/ Ailments	_____ Rashes	_____ Whiplash
_____ Colitis	_____ Hemophilia	_____ Ringworm	_____ **Pregnant/ trying**

Other: _____

Accidents, Injuries or Surgeries:

Less than 5 years ago: _____

More than 5 years ago: _____

Are you currently receiving medical or chiropractic care? If yes, explain. _____

_____

Are you currently taking any medications, prescription & over-the-counter? If yes, explain. _____

_____

Present Complaints:

Please describe your current problem: _____

_____

How and when the problem began: _____

What makes it better or worse: _____

Describe your current pain symptoms:

Intensity 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

☐ Shooting ☐ Throbbing ☐ Dull ☐ Sharp/ Stabbing ☐ Burning ☐ Numbness / Tingling ☐ Sore

Anything else you're experiencing right now? _____

_____

_____