



ARCHER FAMILY  
WELLNESS CLINIC  
5512 NE 109th Court,  
Suite A  
Vancouver, WA 98662  
PH: 360-885-4715  
FAX: 360-859-3741

# Massage Patient Intake Form

For appointment call 360-609-7074



ALLEN CHIROPRACTIC  
CLINIC  
811 NE 112th Avenue,  
Suite 101  
Vancouver, WA 98684  
PH: 360-892-2226  
FAX: 360-892-1204

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone #: \_\_\_\_\_

How did you find out about my service:

\_\_\_\_\_

Have you ever had a massage before? Yes No

What is your primary complaint:

\_\_\_\_\_

Please rate your pain: Mild Moderate Severe

Is the pain: Occasional Intermittent Frequent Constant

What activities increases your symptom:

\_\_\_\_\_

What activities decreases your symptom:

\_\_\_\_\_

## History

Heart Problems yes no Diabetes yes no

High Blood Pressure yes no Arthritis yes no

Low Blood Pressure yes no Depression yes no

Cancer yes no Bruise easily yes no

Blood Clotting Issues yes no

Surgeries: \_\_\_\_\_

\_\_\_\_\_

Diseases: \_\_\_\_\_

Medications: \_\_\_\_\_

Is this due to an Automobile Injury or Worker's Compensation? (If so please include dates) \_\_\_\_\_

**Claim & Billing Information**

Claim #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

**Release of Medical Records**

My signature below authorizes the release of my medical records including intake forms, chart notes, reports and billing statements to my attorneys, health care providers and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

**Financial Responsibility**

It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balance. It is also my understanding and agreement that if you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balanced owed on those specific visits will be waived.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_