



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 360-885-4715

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: _____