Structure Bodywork and Massage

4000 Aurora Ave North Suite 216 Seattle, Wa 98103
Phone 206.715.4671 Fax 855.217.5836

Personal Information

Name_____ Married Single Divorced Other
Address:_____City/State/Zip:_____
Date Of Birth:_____Email:_____
Home/Cell Phone:_____Occupation/Employer:_____
Referred by:_____
Emergency Contact:_____Phone:_____

Private Health Insurance

Insurance Co:_____Employer:_____
Policy/Subscriber ID:_____Group Plan:_____
Name of Primary:_____Subscriber Phone:_____
Primary Date of Birth:_____Primary Sex: M or F
Primary Address:_____City/State/Zip:_____
Relationship to Primary?_____

Auto Accident Insurance

WE DO NOT ACCEPT THIRD PARTY CLAIMS (This must be your insurance directly for **PIP** insurance)
Medical Claim number:_____Date opened:_____Date of injury:_____
Insurance Co. name:_____Phone:_____
Claim Submission Address:_____City/State/Zip+4_____
Adjuster's name:_____Phone:_____

Worker's Compensation Claim

Claim Number:_____Date opened:_____Date of injury:_____
Insurance Co. name:_____Phone_____
Claim Submission Address:_____City/State/Zip+4_____
Adjuster's name:_____Phone:_____

I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO THE INSURANCE COMPANY LISTED FOR THE PURPOSE OF COLLECTING DEBTS RELATED TO MY TREATMENT. I ALSO UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES UNPAID BY INSURANCE COMPANY REGARDLESS OF DENIAL REASON. I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO STRUCTURE BODYWORK AND MASSAGE. I ALSO AGREE THAT IF FOR ANY REASON AN APPOINTMENT IS MISSED OR A MINIMUM OF 6 HOURS NOTICE FOR AN APPOINTMENT THAT NEEDED TO BE CANCELLED OR RESCHEDULED ISN'T GIVEN I ACCEPT THE CHARGE OF 50% OF APPOINTMENT FEE.

Signature:_____**Date**:_____

Y or N Do you have arthritis? If yes, where?_____

Y or N Do you have varicose veins or blood clots? If yes, where?_____

Y or N Do you have high blood pressure? Is it under control/regulated?_____

Y or N Are you pregnant? If yes, what stage/week?_____

Y or N Do you have spinal problems? If yes, where and what is diagnosis?_____

Y or N Do you exercise regularly? Please list._____

Y or N Do you have infectious or contagious diseases? Please list._____

Y or N Do you take any medications? Please list. _____

_____

_____

Y or N Have you ever had surgery? Include oral. Please list along with date(s)._____

_____

Y or N Have you ever suffered a severe injury? Please list along with date(s)._____

_____

Y or N Do you have any skin problems or allergies? Please list._____

Majority of pain is located:_____

Daily activities that aggravate pain and/or tension:_____

_____

_____

Rate pain without activity 1 2 3 4 5 6 7 8 9 10

Rate pain with activity 1 2 3 4 5 6 7 8 9 10

Is the pain and/or tension

constant (always there)?_____ frequent(often there)?_____intermittent(sometimes there)?_____

Any other questions, comments or

concerns?_____

_____

_____

If you have been involved in an accident please provide a detailed description of what happened and date of incident._____

_____

_____

_____

_____

Signature:_____Date:_____

(Patient, Parent or Guardian)