

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 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)