



A Renaissance Health Center for Natural Medicine

130 NW Miller Ave., Gresham, OR 97030 PH: 503.665.2344

MASSAGE & BODY TREATMENT INTAKE FORM

Patient Personal Information:

Name _____ Date ___/___/___

Address _____

City/State/Zip _____

M F Date Of Birth ___/___/___ Age _____

Occupation _____

How did you find us? _____

Phone numbers/ best time to reach you:

Home: ___-___-___ Time _____

Work: ___-___-___ Time _____

Cell: ___-___-___ Time _____

Email Address: _____

Emergency Contact: _____

Phone: _____

Insurance Patients Only

Auto/Worker's Comp Insurance:

Is condition due to accident? Auto Work

Accident Date: ___/___/___ Claim Filed? Yes No

Claim # _____

Insurance Company _____

Group Health Plan Insurance:

Insurance Co. _____

Policy Holder _____

Relationship to Patient _____

Policy Holder's SS# _____-_____-_____

ID # _____ Group Plan # _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company. I assign all insurance benefits, if any, otherwise payable to me for services rendered, directly to my therapist at A Renaissance Health Center. I understand that **I am financially responsible** for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date ___/___/___

Patient/Guardian Signature

Patient Condition

Desired results of massage: ___ Decrease current pain ___ Decrease chronic pain ___ Decrease inflammation ___ Better Sleep
 ___ Decrease muscle tension ___ Improve circulation ___ Injury/Surgery recovery ___ Stress Reduction
 ___ Increase Flexibility ___ General Well Being

Chief Complaint _____ When did symptoms begin? _____

What helps or aggravates condition? _____

Pain is: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling

Radiates to: _____ Pain scale of 1-10 ___/10

Other symptoms (current or just at onset) _____

Other treatments you have received or are currently receiving?
 Medical Doctor Naturopathic Chiropractor Acupuncture Physical Therapy Psychotherapy Other _____

May I consult with your practitioner(s)? _____ Initial _____

Name/Title _____ Contact _____ Name/Title _____ Contact _____

Have you ever received professional massage? _____ How often? _____

Major sources of stress: _____ Self Care Activities _____

Are you pregnant? _____ Due _____ Complications? _____

Please list any medications: _____

