Motor Vehicle Accident - Confidential Client Information

Name: _____ Date of Birth: _____
First M.I. Last MM/DD/YYYY

Address: _____
Street City State Zip

Phone Number: _____ E-mail: _____

Primary Care Physician: _____
Name Clinic Name and Phone #

Insurance Information:

Auto Insurance : _____
Company Name Policy #

Claim#: _____ Date of Incident: _____

Claim Adjustor: _____
Name Phone # Fax #

Primary Insured: _____
Name Street Address City, State, Zip

Primary Insured's DOB: _____ Relationship to Primary Insured: _____

Health Insurance: _____
Company Name Policy ID #

Emergency Contact: _____
Name Phone # Relationship

Attorney (if applicable): _____
Name Office Name Phone #

Referring Medical Provider: _____
Name Clinic Name

Phone Number: _____ Permission to consult (circle one): Yes No

Accident Information:

Date of Accident_____

Description of Incident and Resulting Injuries:

_____

_____

_____

_____

Barrie Robbins, LMT #17639, CTP
tragermoves.com 541-241-2087

SYMPTOMS:

□Aching	□ Difficulty eliminating	□ Fatigue	□ Radiating Sensation	□ Stress
□ Blurred vision	□ Discomfort	□ Headaches	□ Sharp pain	□ Swelling
□ Breathing difficulty	□ Disorientation	□ Irritability	□ Shooting pain	□ Tenderness
□ Burning sensation	□ Dizziness	□ Muscle Spasms	□ Sleep difficulty	□ Throbbing
□ Coughing	□ Dull pain	□ Nausea	□ Sneezing	□ Tightness
□ Cracking noises	□ Ear buzzing	□ Numbness	□ Soreness	□ Tingling
□ Cramping	□ Ear ringing	□ Popping sounds	□ Stiffness	□ Weakness
□ Difficulty arising				

Please mark affected areas

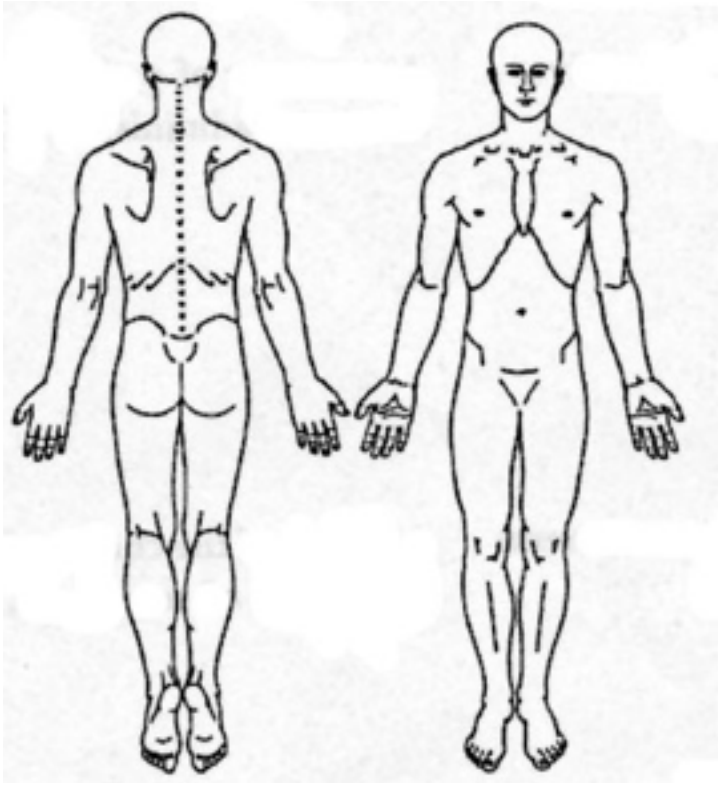
Symptoms are in the:

□ Head □ Jaw □ Neck □ Wrists □ Hands

□ Hips □ Thighs □ Legs □ Ankles □ Feet

□ Chest □ Shoulders □ Buttocks □ Abdomen

Back: □ Upper □ Middle □ Lower



Symptoms are worsened by:

□ Driving □ Exercise □ Lifting □ Bending

□ Cold □ Work □ Standing □ Sitting

□ Twisting □ Walking □ Daily Activity

□ Other _____

Symptoms are eased by:

□ Lying Down □ Resting □ Hot Packs □ Cold Packs

□ Medication □ Massage □ Activity

□ Other _____

Barrie Robbins, LMT #17639, CTP
tragermoves.com 541-241-2087

Medical History

Please check Yes or No to the following questions, and explain in spaces provided:

YES NO

- ☐ ☐ Are you wearing any medical devices? ☐ Contacts, ☐ Dentures, ☐ Hearing Aid, ☐ Other _____
- ☐ ☐ Do you suffer from any of the following?
  - ☐ Skin disorders: ☐ Rash, ☐ Yeast, ☐ Fungus, ☐ Psoriasis, ☐ Infection, ☐ Other _____
  - ☐ Allergies: ☐ Oils, ☐ Nuts, ☐ Skin care ingredients, ☐ Other _____
- ☐ ☐ Are you under the care of a physician for any reason? Please explain _____
- ☐ ☐ Are you taking any medications? If yes, when was your last dose?_____
- ☐ ☐ Any recent/current illnesses? ☐ Infectious, ☐ Viral, ☐ Bacterial, ☐ Other _____
- ☐ ☐ Have you ever been diagnosed with any of the following conditions?
  - ☐ Arthritis. Type and location(s) _____
  - ☐ High blood pressure, ☐ Low blood pressure, ☐ Aneurism, ☐ Embolism, ☐ Other_____
  - ☐ Heart Disease
  - ☐ Diabetes: ☐ Type I, ☐ Type II (Adult Onset), ☐ Other _____
  - ☐ Cancer. Type and location(s) _____
  - ☐ Spinal condition: ☐ Scoliosis, ☐ Osteoporosis, ☐ Other _____
  - ☐ Other medical condition(s)_____

  Date(s) of diagnosis of any of the above conditions _____
- ☐ ☐ Have you ever had surgery? Affected area of the body_____ Date/Year(s) _____

Are you currently taking any medications? Please list: _____

_____

What are your primary goals for your massage treatment(s)?

_____

_____

_____

Barrie Robbins, LMT #17639, CTP
tragermoves.com 541-241-2087

Client Agreement:

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for therapeutic massage treatment. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. ***Initial*** ____

Cancellation Policy:

Your scheduled appointments are reserved exclusively for you. Please call your therapist as soon as you know you cannot keep an appointment. All missed appointments, and cancellations made after 5pm the business day preceding your scheduled appointment, will be billed for the time reserved. You are responsible for these charges, and payment will be expected by the time of your next visit. If you miss two appointments without notice, your treatment will be terminated. Your courtesy and cooperation are appreciated. ***Initial*** _____

Release of Medical Records:

I authorize the release of medical records or other health information, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, healthcare providers, and insurance case managers, for purpose of processing my claims. ***Initial*** ____

Assignment of Benefits:

I am responsible for all charges for all services provided. In the event that my insurance company denies payment, or makes partial payment, I am responsible for any balances due. I authorize and direct payments of medical benefits to Barrie Robbins Bodywork. ***Initial*** ____

By my signature, I verify that all information provided is true and correct to the best of my knowledge. Furthermore, I agree to abide by these policies.

Signature: _____ Date: _____

Barrie Robbins, LMT #17639, CTP
tragermoves.com 541-241-2087