



DEEP TISSUE SPOKANE

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CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

FIRST NAME _____ M.I. _____ LAST NAME _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONE (H) _____ (W) _____ (C) _____
 EMAIL ADDRESS _____
 DATE OF BIRTH _____ SS# _____
 MARITAL STATUS _____ SPOUSE'S NAME _____
 REFERRED BY _____ RELATIONSHIP _____
 EMPLOYER _____ OCCUPATION _____
 IS IT APPROPRIATE TO CONTACT YOU REGARDING YOUR MESSAGE AT THE ABOVE NUMBERS? Y__N__

MESSAGE EXPERIENCE

IS THIS YOUR FIRST PROFESSIONAL MESSAGE? Y__N__ IF NO, HOW FREQUENTLY DO YOU GET A MESSAGE? _____

WHAT DO YOU HOPE TO ACCOMPLISH FROM TODAY'S MESSAGE? _____

ARE YOU AWARE OF ANY TENSION HOLDING SPOTS IN YOUR BODY? Y__N__

IF YES, LOCATION(S): _____

MEDICAL HISTORY

DESCRIBE ANY SURGERIES, HOSPITALIZATIONS, ACCIDENTS OR INJURIES YOU HAVE HAD:

LESS THAN 5 YEARS AGO: _____

MORE THAN 5 YEARS AGO: _____

WHAT KIND OF CARE DID YOU RECEIVE FOR YOUR ACCIDENTS OR INJURIES? _____

DO YOU FEEL THAT YOU HAVE RECOVERED FROM THESE EVENTS? Y__N__

PLEASE EXPLAIN: _____

MEDICAL PROVIDER INFORMATION

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? Y__N__

IF SO, WHO? _____

PLEASE LIST REASON(S): _____

MEDICATIONS

PLEASE LIST ANY MEDICATION (VITAMINS, HERBS OR PHARMACEUTICALS) TAKEN NOW OR AT REGULAR INTERVALS: _____

(INCLUDE INFORMATION OF WHAT MEDICATION IS USED TO TREAT): _____

CURRENT MEDICAL COMPLAINTS/CONDITIONS

DO YOU SMOKE? Y__N__ DO YOU HAVE ANY CHRONIC, ONGOING PAIN THAT YOU DEAL WITH ON A REGULAR BASIS? _____

DESCRIBE WHAT ACTIVITIES CAUSE THIS PAIN AND/OR MAKE IT WORSE? _____

ARE YOU RECEIVING ANY OTHER TYPE OF MEDICAL TREATMENT? Y__N__

PLEASE EXPLAIN: _____

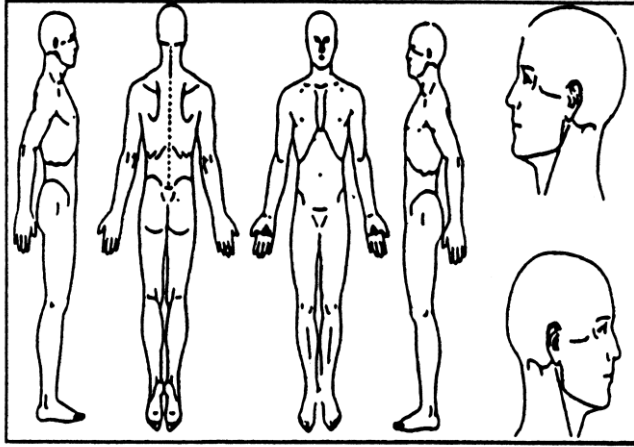
MEDICAL DOCTORS NAME _____

CHIROPRACTIC DOCTORS NAME _____

ARE THERE ANY OTHER HEALTH CONCERNS YOU WISH TO DISCUSS TODAY? Y__N__

IF YES, PLEASE DESCRIBE _____

PLEASE SHADE IN WHERE YOU EXPERIENCE PAIN ON THE DRAWING BELOW



ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?

PREGNANCY FLU OR COLD INFLAMMATION FEVER INFECTION CONTAGIOUS DISEASE

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY AFFECT YOU OR THAT YOU HAVE EXPERIENCED IN THE LAST 5 YEARS:

Are you having any **MUSCULOSKELETAL** conditions/diagnosis'/problems?

Are you having any **RESPIRATORY** conditions/diagnosis'/problems?

Are you having any **CIRCULATORY** conditions/diagnosis'/problems?

Are you having any **DIGESTIVE** conditions/diagnosis'/problems?

Are you having any **SKIN** conditions/diagnosis'/problems?

Are you having any **NERVOUS SYSTEM** conditions/diagnosis'/problems?

Are you having any **OTHER** conditions/diagnosis'/problems?

THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MASSAGE THERAPISTS DO NOT DIAGNOSE DISEASE, PRESCRIBE MEDICATIONS OR MANIPULATE BONES. I FURTHER UNDERSTAND THAT MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION OR EXAMINATION. I TAKE RESPONSIBILITY FOR ALERTING MY PRACTITIONER TO ANY PHYSICAL, MENTAL OR EMOTIONAL CHANGES THAT OCCUR WITH MY HEALTH. I ALSO UNDERSTAND THAT CANCELLED OR MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE (MEDICAL EMERGENCIES OR ILLNESSES EXCLUDED) MAY BE CHARGED IN FULL FOR THE COST OF THE MISSED SESSION.

SIGNATURE _____ DATE _____

Disclosures and agreements

1. **Information Release** - I authorize the release of any medical information necessary to process this claim. Initials _____
2. **Services Agreement** - All insurance policies, even for automobile injuries, are a contract between the insurance company and the patient. We are willing to bill your insurance company for you, but you are responsible for all payments on your account. Initials _____
3. **Payment Authorization** - I authorize payment of medical benefits to my massage therapist for services rendered. Initials _____
4. **Regarding Motor Vehicle Accident Patients:** To ensure payment will be met for services rendered, a lien will be filed beginning the first treatment. The lien will be against the insurance company responsible for payment, the tort-feasor (at fault driver) and the patient, respectively. The charge for filing the lien is \$105 and responsibility for payment is in the order mentioned in the previous sentence. Initials _____
 - 4a. Please answer the following question to ensure accurate filing information:
 1. Location of accident, city, state: _____
 2. Date of accident: _____
 3. Name of tort-feasor: _____
 4. Address of tort-feasor: _____

Contract for Care: I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my therapist any time I feel my well-being is threatened or compromised. I expect my therapist to provide safe and effective treatment. Initials _____

Consent for Care: It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health condition that I am aware of and will inform my therapist of any changes in my health. Initials _____

Length of treatment	Insurance Fees	Payment at time of service
90 Minutes	N/A	\$80
55 Minutes	\$90	\$55
Punch card * (5-50 Minutes)	N/A	\$235

INCENTIVE PROGRAM	REFER A FRIEND - RECEIVE A FREE HALF HOUR
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Cancellation Policy: Same day cancellation or a "no show" may result in a \$30.00 charge.

Date _____

Signature _____

Signature of Parent/Guardian _____