Synergy Health & Wellness 361 NE Franklin Ave. Bldg C, Bend OR, 97701 (541) 323-3488

PATIENT INFORMATION (Please print clearly) Date_____

Name_____ SSN_____

Address_____ City _____ State_____ Zip_____

Gender Pronoun: She / He / They / Ze / _____ Birth Date: _____

Email:_____

Cell phone:_____ Work/Home phone:_____

Employer:_____Occupation:_____

Emergency Contact Name:_____ Phone:_____

Whom may we thank for referring you?:_____

Your signature agrees to our 24 hour cancellation policy, and acknowledges that any future cancellations made less than 24 hours prior will be subject to a fee equal to the full cost of the missed session. Our system requires a credit card on file to enforce our cancellation policy. Your card will not be charged, except in the case of no-show or cancellation less than 24 hours in advance. Your card will never be charged without notification.

Printed Name _____

Signature_____ Date _____

(parent signature if patient is a minor)

INFORMATION FOR INSURANCE BILLING ONLY Please provide all insurance cards at time of visit

Type of policy (i.e. Health, auto, workers comp): _____

Insured's name: _____ Insured's date of birth: ____/____/_____

Adjuster name and contact: _____

Do you have a secondary Insurance?
If yes—Name of secondary insurance company: _____

ASSIGNMENT AND RELEASE: I certify that I have insurance coverage with the above listed company and assign directly to the providers of Synergy Health and Wellness all insurance benefits. I authorize the use of my signature on all insurance submissions. Additionally, the care provider may use and disclose my health care information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits related services. **My signature below certifies that I agree to pay any deductible, copayment and coinsurance at the time of service, and in the event payment is denied on the above claim. I will assume responsibility for payment of services rendered. (payment plan may be implemented). I am aware that insurance does not cover no-show or late cancellation charges, and I accept full responsibility for any fees related to this occurrence.**

Signature: _____ Date _____

I have read and accepted the privacy practices Sign_____ Date_____

I was offered privacy practices and declined to read Sign_____ Date_____

LMT

What brings you in for treatment?

Please list any medications you are currently taking and what condition they are for:

_____

_____

Are you/could you be pregnant?

Are you currently under a physician's care? If so, who and what for?

Date of last physical exam:_____

List <u>any</u> falls, motor vehicle accidents or other traumas you have been involved in (include dates):

_____

_____

List <u>any</u> surgeries you have had:

_____

_____

HEALTH HISTORY ***<u>STOP!!!</u> Read this **********(check all that apply to ***<u>you</u>***)

Do you have a PERSONAL history of problems in any of the following...

___ Allergies (to what?)
___ Arthritis
___ Cancer
___ Cardiovascular
___ Chronic Headaches
___ Endocrine
___ Fractures
___ Gastrointestinal
___ Hernia
___ Herniated Disk
___ High Blood Pressure
___ High Cholesterol
___ Immune
___ Musculoskeletal
___ Neurological
___ Osteoporosis
___ Pinched Nerve
___ Psychological
___ Reproductive
___ Respiratory
___ Skin Problems
___ Sleep Disorder
___ Stroke
___ Urinary

___ Other (explain)

DAILY HABITS

What type of exercise do you do regularly: ❒none ❒light ❒moderate ❒heavy

What do your daily work habits include: ❒sitting ❒standing ❒light labor ❒heavy labor ❒other:

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Do you drink caffeinated beverages: ❒no ❒yes (type and amount):

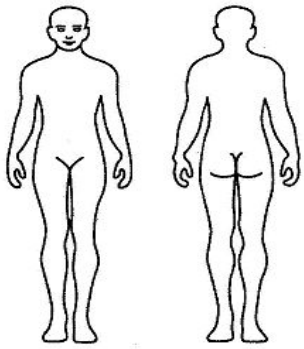
Do you drink alcohol: ❒no ❒yes (How many drinks per week?):

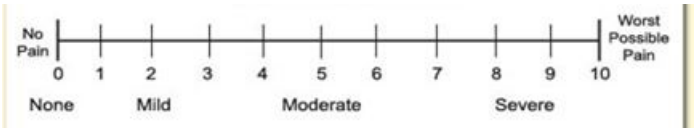
Do you use other recreational drugs?

Is there anything else that may be related to your condition that we have not asked?

Have you received massage before? When was your last massage?

Please mark any areas where you feel pain or soreness





What level of pressure do you desire today? ❒Gentle ❒Medium/Firm ❒Very Firm ❒Hard

Your therapist will interact with you to gauge pressure during the session, and to ensure that your needs are being met. Please note that it is ultimately YOUR responsibility to communicate pressure needs during the session. Initial for understanding _____

What level of therapist interaction do you like during session?
❒Total silence other than to check pressure ❒Chat when I initiate it ❒I like a chatty therapist

What temperature do you like during sessions?
❒Cool ❒Room Temp/Average ❒Crank up the heat!

Your signature below certifies that the information you have provided on this intake form is accurate and you agree to accept treatment. Signature signifies understanding and consent to massage therapy treatment which may in some rare cases carry risks including but not limited to swelling, bruising, joint pain or dislocation, musculoskeletal injury, skin irritation, and other rare complications.

Printed Name _____

Signature_____ Date _____

(parent signature if patient is a minor)