Vitality Therapeutic Message & Yoga INTAKE FORM

Patient Information

Name: _____ Today's Date_____
Last First M.I.

Address: _____
Number Street City State Zip

Phone numbers: _____ Email: _____
Home Alternate

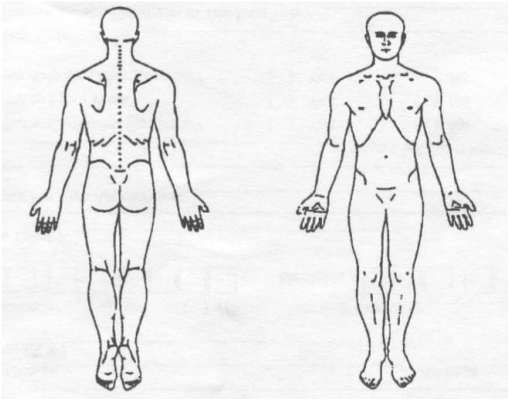
Date of Birth: _____ Occupation: _____

Emergency Contact: _____Emergency Phone: _____

Referred by: _____

Symptoms

Please mark an "X" at any area of discomfort on the diagram.



Please circle which, if any, of the below activities are painful.

Sitting Walking
Bending Twisting
Standing Running
Lying Down Lifting

Please circle the type of pain or discomfort you experience.

Shooting Tingling
Dull Sharp
Stiff Achy
Numb
Throbbing

Please describe your chief health concern(s): _____
_____

Health History

Have you had any recent illnesses, accidents or surgeries? ( )Y ( )N If yes, please explain _____

List All Current Medications, Vitamins, and Supplements -- Include Prescription, Over the Counter & Herbal _____

Do you have problems with any of the following? *Please mark "C" for current conditions, and "P" for Past:*

C	P		C	P	
( )	( )	Diabetes	( )	( )	Headaches
( )	( )	Skin Problems	( )	( )	Allergies
( )	( )	Circulation Problems	( )	( )	Pregnancy
( )	( )	Cancer	( )	( )	Heart Disease
( )	( )	Chronic Illness	( )	( )	Arthritis
( )	( )	High Blood Pressure	( )	( )	Seizures
( )	( )	Infection	( )	( )	Other

Insurance Information

Auto Insurance – fill in part A and C only
Health Insurance – fill in part B and C only

PART A

Name of Insurance Co: _____ Date of Injury: _____

Address: _____ Phone Number: _____

Claim/Policy No. _____ Contact Person: _____

Name of Insured: _____ Relation to Patient: _____

Attorney (if any):_____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

PART B

Name of Insurance Company: _____ Name of Insured: _____

ID No. _____ Group No: _____

Part C

I authorize the release of medical records necessary to process this claim. I authorize payment by insurance company be made directly to the provider of services.

I understand the fees for services rendered will be directly billed to the above listed insurance company. I understand that I will be billed and held responsible for any fees for any services unpaid or not covered by the insurance company.

Signature _____ Date _____

Cancellation Policy: In order to avoid a 50% charge to your credit card, please provide Vitality Therapeutic Massage & Yoga at least 24 hour notice when rescheduling or canceling your appointment._____ (initial)