Health Information

19 Bellwether Way, Ste 101
Bellingham, WA 98225
360 647 2805 fax 360 734 4148

Today's Date:________________________________

Referred by:_________________________________

Personal Information

Name:____ Email Address:____

Address:____ Home Phone:____

City/State/Zip:_______________________________________ Cell Phone:____

Physician:____ Date of Onset/Injury:____________________________________

Date of Birth:_______________________________________ Emergency Contact:______________________________________

Gender: Male Female Non-Binary Emergency Phone:_____________________________________

Current Condition:

What part of your body is in pain or discomfort?:____

When did your symptoms appear?____

What treatment have you already received for this condition?____

Circle all of the descriptions that apply to you: Sharp Dull Throbbing Aching Shooting

Burning Tingling Numbness Stiffness Cramping

Swelling Other:_____________________________________

How often do you have this condition/pain?____

Does it interfere with your:______Work _______Sleep ______Daily Routine ________Recreation?

Activities or movements that are painful to perform: _______Standing _______Sitting _______Walking

______Bending ______Lying Down _______Twisting or Turning Other:________________

Health History:

Have you ever received a professional massage?_________________

Are you currently under the care of a health care provider? YES NO If yes, for what?______________________________

____

Are you currently taking any medication? YES NO If yes, please list_______________________________________

____

What do you do to relieve stress in your life?____

Do you exercise regularly or participate in any sports? If yes, what kind and how often?______________________________

____

Circle all of the conditions or symptoms you currently have, or have had in the past:

Anemia	Cancer	Head Injury	Migraine Headaches	Other:________________
Appendicitis	Chemical Dependency	Heart Disease	Osteoporosis	________________
Arthritis	Diabetes	Hepatitis	Stroke	________________
Asthma	Emphysema	Hernia	Tendonitis	_________________
Blood Clots	Epilepsy	Herniated Disc	Tumors, Growths	
Breathing Difficulty	Fibromyalgia	High Bood Pressure	Ulcers	
Bursitis	Eating Disorder	HIV/AIDS	Varicose Veins	
Bronchitis	Fractures	Lymphedema	Whiplash	

Payment Policies

In fairness to our other patients and to us, 24-hour notice is required for cancellation of an appointment unless there is an emergency, or **you will be charged $45**. We do not bill your insurance company for missed appointments or late cancellations; you are responsible. Payment is due before your next appointment.

Financial Responsibility

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company for covered services. Your signature below confirms that it is your responsibility to pay for all services provided. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance.

Assignment of Benefits

Your signature below authorizes and directs payment of medical benefits for services billed to the health care provider at this office.

Release of Medical Records

Your signature below authorizes the release of all your medical records on file in this office to your attorneys, health care providers, and insurance case managers, for the purpose of processing your claims, unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature:____ Date:_______________________