Meridian Medical Massage LLC

3863 SW Hall Blvd. Suite B Beaverton, OR 97005
MeridianMedicalMassage@gmail.com
Phone. (503) 446-0698
Fax. (503) 214-8790

PATIENT INFORMATION

Name_____ Date of Birth_____
Address_____
City_____ State_____ Zip_____
Phone_____ Email_____
Whom may we thank for referring you?_____

IN CASE OF EMERENCY

Name _____ Relationship_____ Phone _____

HEALTH HISTORY

Date and Description Of Last:
Physical Exam _____
X-Ray_____
MRI/CT-scan/Bone Scan_____
Injuries/Surgeries _____

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking Packs/Day_____
- ☐ Alcohol Drinks/Day _____
- ☐ Caffeine Drinks/Day _____
- ☐ High Stress

Please mark any conditions you have had/currently have

- ☐AIDS/HIV
- ☐Anemia
- ☐Anorexia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bleeding Disorders
- ☐Breast Lump
- ☐Bronchitis
- ☐Bulimia
- ☐Cancer
- ☐Depression
- ☐Diabetes
- ☐Emphysema
- ☐Epilepsy
- ☐ Gout
- ☐Heart Disease
- ☐Hernia
- ☐Herniated Disk
- ☐Kidney Disease
- ☐Liver Disease
- ☐Measles
- ☐Migraines
- ☐Miscarriage
- ☐Multiple sclerosis
- ☐Osteoarthritis
- ☐Pacemaker
- ☐Parkinson's
- ☐Pinched Nerve
- ☐Rheumatoid Arthritis
- ☐Stroke
- ☐Thyroid Problems
- ☐Tumors/Growths

Other

Are you pregnant? ☐ Yes ☐ No
Please list any allergies _____
Please list any vitamins, herbs or medications you are taking _____

Signature_____ Date_____

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INSURANCE INFO

Insurance Company _____ Claim Number _____
Adjuster's Name_____ Phone_____
Patient relationship to the insured (If 'Self' you can leave the following information blank)
☐ Self ☐ Spouse ☐ Child ☐ Other
Name of insured_____ DOB_____
Address_____
City_____ State_____ Zip_____
Phone_____ ☐ Male ☐ Female

ACCIDENT INFORMATION

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other_____ Date of accident_____
To who have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Attorney ☐ Other _____
Attorney name_____ Phone _____
Please describe the accident in your own words_____

_____
Where were you seated in the car? _____
Where was the impact from the ☐ Front ☐ Rear ☐ Left ☐ Right
Was your foot on the brake_____ Were you wearing a seatbelt?_____
Did any part of your body strike the vehicle? If so please explain_____

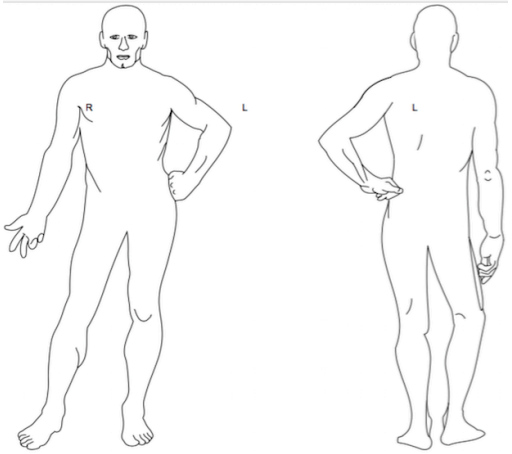
_____

PATIENT CONDITION

What treatment have you received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic ☐ Acupuncture ☐ Other_____
Is the condition getting progressively worse? _____
Rate the severity of your pain from 0 (least) to 10 (most severe) 0 1 2 3 4 5 6 7 8 9 10
Type of pain ☐ Sharp ☐ Dull ☐ Tingling ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other_____
Is the pain constant or does it come and go?_____
Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Painful movements ☐ Sitting ☐ Bending ☐ Standing ☐ Lying Down ☐ Walking

Please circle any symptoms you have had since your injury

☐ Arm/Shoulder pain
☐ Back Pain
☐ Back Stiffness
☐ Chest Pain
☐ Dizziness
☐ Ear Buzzing
☐ Ear Ringing
☐ Feet/Toe Numbness
☐ Hand/Finger Numbness
☐ Headaches
☐ Irritability
☐ Jaw Issues
☐ Leg Pain
☐ Memory Loss
☐ Nausea
☐ Neck Pain
☐ Neck Stiffness
☐ Shortness of Breath
☐ Sleep Issues
☐ Tension
☐ Vision Blurred



Mark an X on the picture where you have pain, numbness or tingling

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INFORMED CONSENT AND RELEASE

Please initial

_____I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Oregon Board of Massage Therapy.

_____I hereby consent my therapist to treat me with manual therapy for the above noted purposes including such assessments, examinations, and techniques, which may be recommended by my therapist.

_____I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that manual therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance of guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

_____I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and have disclose to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

_____I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

_____I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and from which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____I certify that I, and/or my dependent(s) have insurance coverage with (Name of Insurance Co.) and assign directly to Meridian Medical Massage LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____I authorize my therapist to use my health care information and s/he may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____To the best of my ability the above information is correct. I understand that it is my responsibility to inform Meridian Medical Massage LLC of any changes to my health or insurance benefits.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient