
4160 SE Division Street | Portland, OR 97202
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## Workers' Compensation Intake Form

Name: _____ Date: _____
Referred by: _____
Address: _____
Phone: _____ Birthday: _____
Occupation: _____ E-mail: _____
Emergency Contact: _____ Phone: _____
Have you received massage therapy before? _____ If so what type? _____
Would you like to receive our monthly email newsletter with special offers? ___ yes ___ no

**Insurance Information**
Insurance Company: _____ Date of Injury: _____
Insurance Contact Name: _____ Claim #: _____
Insurance Company Address: _____
Insurance Phone #: _____ Fax # :_____

Please mark past (p) or current (c) conditions which apply to you:

__Low Blood Pressure
__Athlete's Foot
__TMJ Disorder
__Indigestion
__Fibromyalgia
__Varicose Veins
__Constipation
__Plantar Fascitis
__Numbness
__Stroke
__Arthritis
__Fatigue
__Diabetes
__Asthma
__Heart Disease
__Depression
__Stiffness
__Skin disorders
__Communicable Diseases
__Osteoarthritis
__PMS Syndrome
__Sleep Disorders
__Dizziness
__High Blood Pressure
__Compromised Immunity
__PTSD
__Allergies
__Spinal Injury
__Bursitis
__Headaches
__Broken Bone
__Sciatica
__Cancer
__Anxiety

Please indicate all of the symptoms which you feel are a result of this accident.

___Neck pain
___Neck stiffness
___Jaw problems
___Headache
___Visual disturbances
___Auditory disturbances
___Numb feet/toes
___Numb hands/fingers
___Chest pain
___Shortness of breath
___Shoulder pain
___Mid-back pain
___Low back pain
___Leg pain
___Tingling in extremities
___Difficulty swallowing
___Memory loss
___Difficulty sleeping
___Irritability
___Disorientation
___Confusion
___Nausea
___Fatigue
___Dizziness/Fainting
___Loss of sense of smell
___Other:

How long after the accident did symptoms begin? _____
How frequent are the symptoms? _____
Please rate the severity on a scale from 1-10 (1 = slight discomfort and 10 = extreme pain):
_____

To help evaluate the effect that your job duties will have on your recovery, please indicate :
How many hours are in your normal work day? _____
How many hours do you work each week? _____

Your daily job duties and any activities which you are occasionally asked to perform:
Daily: Standing ___ Driving ___ Operating equipment ___ Working with arms over head ___
Walking ___ Lifting ___ Sitting ___ Other _____
Occasional: Standing ___ Driving ___ Operating equipment ___ Working with arms over head ___
Walking ___ Lifting ___ Sitting ___ Other _____

Other information about the accident you'd like to share:

Are you currently under a physician's care? For what? Please explain any current health problems.

Please list any surgeries, accidents or major illnesses in the last five years.

Are you taking any medications, vitamins, or supplements?

What are the primary sources of stress in your life?

Where in your body do you hold stress?

What do you do to relax?

What do you do to exercise?

What are your current goals for massage?

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## Informed Consent and Business Agreement

Full Payment is due at the time of treatment. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment cancelled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, an arrangement may be made to omit payment and await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider, _____, to release my medical records relating to claim for benefits submitted.

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 hereby give my consent to receive therapeutic massage.

Signature: _____ Date: _____