Still Life Massage and Float
19 Bellwether Way, Ste 101
Bellingham, WA 98225
360 647 2805   fax 360 734 4148

Health Information

Today's Date:______________________________

Personal Information

Name:____
Address:____
City/State/Zip:____
Physician:____
Date of Birth:____
Sex: Male   Female

Referred by:____________________________________
Home Phone:___________________________________
Cell Phone:____________________________________
Date of Onset/Injury:_____________________________
Emergency Contact:______________________________
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	

PLEASE TURN PAGE OVER

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 for the appointment. 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:______________________