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

Referred by:_________________________________

Name:____
Address:____
City/State/Zip:_____________________________________
Physician:____
Date of Birth:______________________________________
Gender: Male Female Non-Binary

Email Address:____
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?______________________________

____

PLEASE TURN PAGE OVER

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

Abdominal Issues	Edema	Migraine Headaches
Allergies	Emphysema	Osteoporosis
Anemia	Epilepsy	Pacemaker
Appendicitis	Fibromyalgia	Pregnant
Arthritis	Eating Disorder	Psoriasis
Asthma	Fractures	Renal Failure
Blood Clots	Head Injury	Rosacea
Blood Thinners	Heart Disease	Skin Allergies
Bleeding Issues	Hemophilia	Skin Disorders
Botox Injections	Hepatitis	Stroke
Breathing Difficulty	Hernia	Tendonitis
Breast Feeding	Herniated Disc	Transdermal Drug Delivery System
Bursitis	High Blood Pressure	Tuberculosis
Bronchitis	HIV/AIDS	Tumors, Growths
Cancer	Insulin Monitors	Ulcers
Capillary Fragility	Leukemia	Varicose Veins
Chemical Dependency	Liver Failure	Whiplash
Diabetes	Lymphedema	Other:__________________
Eczema	Medical Devices	

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:_________________________