



PERSONAL INFORMATION

THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR MASSAGE NEEDS. PLEASE COMPLETE THIS FORM IN INK. IF YOU HAVE ANY QUESTIONS OR CONCERNS, DO NOT HESITATE TO ASK FOR ASSISTANCE. WE ARE HAPPY TO HELP!

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ ST _____ ZIP _____

SOC. SECURITY # _____ SEX: MALE FEMALE

BIRTH DATE _____ HOME # _____ WORK # _____

ARE YOU: MARRIED SINGLE CELL # _____

YOUR EMPLOYER _____ OCCUPATION _____

SPOUSE/PARENT NAME _____ WORKPLACE _____ WORK # _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE # _____

WHO REFERRED YOU TO OUR OFFICE? _____

E-MAIL ADDRESS _____

INSURANCE INFORMATION

NAME OF SUBSCRIBER _____ RELATIONSHIP _____

SUBSCRIBER DATE OF BIRTH _____ *** PLEASE PRESENT CARD ***

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, CERTIFY THAT I HAVE INSURANCE WITH _____ AND ASSIGN DIRECTLY TO DR. MILLER 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 HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE DATE

HEALTH HISTORY

PLACE A MARK IN THE BOX IF YOU HAVE HAD OR CURRENTLY HAVE THE FOLLOWING:

- ARTHRITIS ... WHERE? _____ DIABETES ASTHMA ULCERS
- MIGRAINES THYROID PROBLEMS HEARTBURN HIGH BLOOD PRESSURE IRRITABLE BOWEL SYND.
- LIVER PROBLEMS INCONTINENCE CANCER... WHERE? _____ WHEN? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

WHO IS YOUR FAMILY PHYSICIAN? _____

SOCIAL HISTORY

HOW OFTEN DO YOU EXERCISE? _____ DO YOU USE TOBACCO? YES NO

DO YOU CONSUME ALCOHOL? YES... HOW MUCH? _____ NO

WHAT IS YOUR WORK ACTIVITY LIKE? SIT STAND DRIVING LIFTING SIT/STAND

WHAT IS YOUR STRESS LEVEL ON A SCALE OF 0 TO 10? _____

WHAT ARE SOME OF YOUR HOBBIES? _____

ABLE TO DO THESE NOW? YES NO