1530 N 115th St. #302
Seattle, WA 98133
T: 206-355-6781
F: 206-365-0663

13433 NE 20th St. #D
Bellevue, WA 98005
T: 425-451-4301
F: 425-957-1406

15228 Woods Creek Rd. SE
Monroe, WA 98272
T: 206-355-6781
F: 425-957-1406

CONFIDENTIAL HEALTH HISTORY FORM

Chief Complaint: _____

Date of first symptom, injury or fall: _____

Have you ever had similar symptoms in the past? ☐ Yes ☐ No

If yes, please explain: _____

Were you hurt as a result of a car accident or an on the job injury? _____

If yes, please explain:_____

Is an attorney helping you with your claim? _____

If so, Name and Phone #: _____

Have you been unable to work because of this injury, missing partial or full-time days? _____

If so, what dates? _____

Have you received massage or chiropractic treatment previously? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No

If yes, what kind _____

_____

List approximate dates of any falls, broken bones, surgeries or diseases you have had: _____

_____

Additional notes or comments you feel would be pertinent to your care_____

_____

_____

Females: Is there any chance of pregnancy? _____

Signature:_____Date:_____

Please Read the Following Carefully Before Signing

Thank you for completing this form as accurately as possible. This information is considered **confidential** and will only be used to help the doctor determine your condition. If the doctor does not sincerely believe your condition will respond satisfactory to massage care, he will not accept your case. If at any time you have any questions, please do not hesitate to ask.

Our office will be pleased to assist you in billing your insurance company. Your insurance company should pay within thirty days after billing. If insurance company does not pay within 60 days, you must pay the balance due and be reimbursed by your insurance company if and when it pays. Our office will not enter a dispute with your insurance company over your claim; Insurance is a contract between the patient and the insurance company, not with the medical provider. It is the policy of this office that should you discontinue care, the balance of your account is due and payable immediately.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which I or my dependents are entitled to under my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the $30 fee (per RCW 62A.2-515 & 520) on check returned NSF. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, shall pay all reasonable collection expenses, interest on unpaid balance at 1% per month from the date of service and/or reasonable attorney fees and court costs.

Signature:_____**Date**:_____