Anik J. St. Martin, DC, D.A.C.C.P.
Darin J. Shook, DC
Craig Werner, DC
John Dobosz, DC

Advantage
CHIROPRACTIC & MASSAGE
1312 Vandercook Way • Longview, WA 98632 • 360.425.6620 • Fax 360.425.1277
www.MyAdvantageChiro.com • contact@myadvantagechiro.com

Amy LaRiviere, LMP
Diane Miollis, LMP
Kim Clark, LMP
Matt Grimm. LMP

MASSAGE INTAKE FORM

Name: ______________________________ Birth Date: ___________ Age: _____ Sex: ☐ M ☐ F

Address: ______________________________ City: ____________________ State ______ Zip _______

Home Phone: ____________________ Cell Phone: ____________________ Email: ____________________

Social Security # ______________________________ Referral/How did you hear about us? ______________

IF THE PATIENT IS A MINOR COMPLETE THIS SECTION

Lives with: ☐ Both Parents ☐ Mother ☐ Father Names and Ages of Siblings: ____________________

Mother's Name: ______________________________ Email Address: ______________________________

Address: ______________________________ City: ____________________ State ______ Zip _______

Home Phone: ______________________________ Cell Phone: ______________________________

Employer: ______________________________ Type of Work: ______________________________

Business Phone: ______________________________ Business Address: ______________________________

Father's Name: ______________________________ Email Address: ______________________________

Address: ______________________________ City: ____________________ State ______ Zip _______

Home Phone: ______________________________ Cell Phone: ______________________________

Employer: ______________________________ Type of Work: ______________________________

Business Phone: ______________________________ Business Address: ______________________________

IF THE PATIENT IS 18 YEARS OF AGE OR OVER COMPLETE THIS SECTION

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Names and Ages of Children: ____

Have you ever had a different name, maiden name? Please list: ______________________________

Business Employer: ______________________________ Type of Work: ______________________________

Business Phone: ______________________________ Business Address: ______________________________

Name of Spouse: ______________________________ Email: ______________________________

Home Phone: ______________________________ Cell Phone: ______________________________

Spouse's Employer: ______________________________ Type of Work: ______________________________

Business Phone: ______________________________ Business Address: ______________________________

THIS SECTION IS REQUIRED BY ALL

Person to Call if Unable to Reach You: ____

Phone # ______________________________ Relationship: ______________________________

Address: ______________________________ City: ____________________ State ______ Zip _______

Authorized Person to Discuss any Account/Health Information: ______________________________

Phone # ______________________________ Relationship: ______________________________

Address: ______________________________ City: ____________________ State ______ Zip _______

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PERSONAL HEALTH INSURANCE

☐ I **do not** have personal health insurance. In the absence of insurance, any non-covered charges become patient responsibility.

Health Insurance Company ______________________________

Billing Address ______________________________

Phone ______________ ID # ______________ Group # ______________

Policy Holder's Name: ______________________________ DOB: ______________

CURRENT HEALTH CONDITION

Purpose of This Appointment: ______________________________

Other Doctors Seen For This Condition: ☐ Yes ☐ No Who? ______________

Type of Treatment: ______________ Results: ______________

When Did This Condition Begin? ______________ Has This Condition Occurred Before? ☐ Yes ☐ No

PAST HEALTH CONDITION

Previous illnesses you've had in your life: ______________________________

____

Have you ever broken any bones? Which? ______________________________

Previous Injury or Trauma: ______________________________

____

____

Medications and reasons for taking them? ______________________________

____

____

Surgeries: Date and type of surgery? ______________________________

____

Allergies: ______________________________

Family Health History: Associated health problems of relatives:

____

____

Deaths in immediate family: Cause of parents or siblings death and age of death Age at death

____

____

Females/ Pregnancies and outcomes: Pregnancies/Date of Delivery/Outcome/Miscarriages

____

____

Patient's Name: ______________________________ DOB: ______________ Date: ______________

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Social and Occupational History:

Job description: ______________________________________

____

____

Work schedule: ______________________________________

____

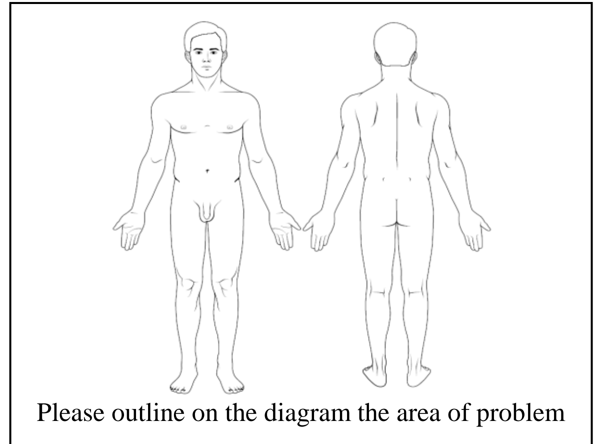
Recreational activities: ______________________________

____

____

Alcohol use: ☐ **Yes** ☐ **No** **Frequency**____________

Tobacco use: ☐ **Yes** ☐ **No** **Frequency**____________



Please outline on the diagram the area of problem

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Headache
- ☐ Loss of sleep
- ☐ Fever

MUSCLE / JOINT / BONE
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Arm pain/numbness/weak
- ☐ Leg pain/numbness/weak
- ☐ Joint pain / Stiffness
- ☐ Walking problems
- ☐ Jaw pain

GENITO-URINARY
- ☐ Blood/discolor in urine
- ☐ Lack of bladder control
- ☐ Painful urination

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

CARDIO-VASC-RESP
- ☐ Chest pain
- ☐ Blood pressure problems
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Blood clots
- ☐ Swelling of ankles

GASTROINTESTINAL
- ☐ Appetite poor / excessive
- ☐ Gas/Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Weight trouble
- ☐ Excessive thirst
- ☐ Indigestion / Heartburn
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

EYE, EAR, NOSE, THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Hearing difficulty
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat

SKIN
- ☐ Bruise easily
- ☐ Rash

MEN only
- ☐ Lump in testicles
- ☐ Other:

WOMEN only
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Menstrual irregularity
- ☐ Other:

Date of last
Menstrual period______________

CONDITIONS Check (✓) conditions you currently have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Gall bladder problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Chemical Dependency
- ☐ Prostate Problem
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Other__________________

I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

Signature of Responsible Party: ______________________________________ Date ________________

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FINANCIAL POLICIES

Payment is expected at the time of service.

We accept the following forms of payment; Cash, Personal Checks, Debit Cards, Visa and MasterCard.

No balance policy: Any patient responsibility is expected at the time of service. Balances after insurance payments and any non-covered charges by insurance are due upon receipt of your statement.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Late Fee: A late fee of $10.00 will be imposed on each account that is over thirty (30) days past-due. All balances will accrue a $10.00 late charge every billing cycle.

Returned checks: There is a $25.00 fee for any checks returned by the bank.

Massage no show/late cancellation fee: If you do not show up for an appointment, or cancel with less than 24 hours' notice, a $10.00 fee will be charged. This late no show /cancellation fee goes directly to our massage therapists for compensation of time loss.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. All delinquent accounts bear interest at the legal rate. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cowlitz County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance Billing: If we are contracted with your insurance company, we must follow our contract and their requirements.

Copays are due at the time of service. It is the insurance company that makes the final determination of your eligibility.
We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.
If you have any visit limit or dollar maximum it is your responsibility to keep track of this and be aware of your benefits.
Insurance coverage is never a guarantee of payment. If there are any problems between the insurance company and the patient, the patient would need to file a grievance directly with the insurance company.
Your signature below indicates assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

Your insurance company determines benefits when they receive our claims. Any statement made by our staff regarding your coverage is in no way a guarantee of payment for your services. I acknowledge that I am responsible for payment of all non-covered services.

Non-Contracted Insurance Billing: If you see a non-contracted (out of network) provider your insurance company may send you a check. You will need to sign the check and return it to our office for services rendered. I acknowledge that I am responsible for payment of all non-covered services.

Medicare: Medicare does not cover the following services at a Chiropractic office: Massage, Exams, Re-exams, X-Rays, Therapeutic exercises, Durable medical equipment or Supplements. We expect payment for any non-covered Medicare service at the time of your visit. If you have a copay with your supplemental insurance, it is to be paid at the time of your visit.

Workers Compensation: We require approval/authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.
In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company. In addition to this verification, we require that you allow us to bill your health insurance if your claim is denied or you exceed your benefits. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

By signing below, I acknowledge that I understand the policies contained herein.

Print Patient's Name: ____

Print Responsible Party's Name (if not the patient): ______________________________

Signature of Responsible Party: ____________________________ Date ______________