Cedar & Sage Therapeutic Massage
PERSONAL HEALTH INFORMATION

Name: ____ Date: _________________________________
Address: ____ Phone-Day: ___________________________
City/State/Zip: ____ Phone-Evening: _______________________
Occupation: ____ Date of Birth___________________________
e-mail ____ Would you like to join our mailing list?___________________

Have you ever had a professional massage: yes no
Areas of the body that you would like to focus on today: ____
Are you currently under the care of a physician: yes no
If yes, for what condition (s) ____ ____________
Do you exercise regularly? yes no ____
List current medications & supplements including aspirin, Ibuprofen, etc.
____
____

Health History
Do you have any of the following conditions? (please circle and list location, time frame, or comment)

joint disease ________________ broken bones___________________ tendonitis_______________________
bursitis ____________________ arthritis_______________________ sprains/strains ____________________
lupus ______________________ breathing difficulty ______________ jaw pain/TMJD ____________________
dislocations _________________ headaches_______________________ spasms/cramps ___________________
heart condition ______________ blood clots _____________________ varicose veins____________________
high/low blood pressure _______ athletes foot ____________________ sinus problems ___________________
allergies ____________________ constipation ____________________ chronic pain _____________________
warts _______________________ irritable bowel __________________ numbness/tingling ________________
diabetes_____________________ pregnancy (stage) ________________ cancer/tumor_____________________

Any other conditions not listed or details regarding above listed:
____
____
Reason for today's visit
____
____
____
____

I realize that this treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel that my well being is in compromise.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder: nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: ____ DA TE: _________

Cedar & Sage Therapeutic Massage
BILLING INFORMATION

Type of Insurance: Please circle Group PIP (Auto) L&I (Workers' Comp.)

Name of Insured: ____ Date of Injury: ___________________________
Employer: ____ Phone: ________________________________
Referring Physician: ______________________________________ Phone: ________________________________
Insurance Company: ______________________________________ Adjusters Name: _________________________
Street Address: ____ Phone: ________________________________
City: ____ State:___________ Zip:__________________
Group #: ____ Plan: _________________________________
Claim #: ____ Member ID#:___________________________

Please read this agreement carefully.
We will be happy to answer any questions you may have.

I understand that my insurance is an agreement between the insurance company and myself. I understand that Cedar & Sage Therapeutic Massage will directly bill my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance company.
I assign payments to be made on my behalf to Cedar & Sage Therapeutic Massage for any services furnished to me.
I authorize my insurance carrier to release such information needed to determine these benefits or to assist in the collection of payment for services.
If the bills for services are not paid by my insurance carrier, I am responsible for the balance.

SIGNATURE: ____ DA TE: _________

For Office Use

Effective Date of Policy: _____________ Rx required? ________ Deductible? Yes No Amount: _________
Is Deductible Met? Yes No Amount Remaining: ____________ Co-Pay Amount: _________________________
Maximum # of Visits: ____________________________________ Maximum Dollar Amount: ________________
Adjuster's Full Name: ___________________________________ Date Verified: __________________________