Belanger Body Care

4630 200th Street S.W   Suite M.
Lynnwood, Washington 98036

Client File Intake Form – Auto Injury

Date: ________________________

Name: ____
Address: ____
City: _____________________________ State: _________________________________
Date of Birth: ___________________
Home Phone: __________________________ Cell: _____________________________
Office: _______________________________

Employer: ____
Occupation: ____
Male ___ Female ___   Name of Spouse: _____________________________________

Date of Accident: ____________________________

Family Physician: _____________________________ Phone: ___________________
Clinic: ____
Other Professionals Seen: ____
How Often: __________________________________

Any previous Accidents that could have an impact on this injury? Yes____ No: ____
Details: ____
Was anyone else was in the car with you? Yes____ No ____
Details: ____
Are you taking any medications in connections with this injury? Yes ___ No ___
Details: ____
Are you taking any other medications we should know about? Yes ___ No ___
Details: ____

Office: 425-670-8851   Fax: 425-673-8630

Before Your Treatment: **Please circle** any recent or chronic medical conditions that you may have::

Dislocations	Back injuries	Neck injuries
Pulled muscles	Fractures	Nausea
Stiff Neck	Mid-Back Pain	Lower Back Pain
Other recent Trauma	Sore Arms	Muscle Cramping
Numbness	Headaches	High Blood Pressure
Arthritis	Inflammation	Fainting Spells

Other: ____

I hereby give consent for Massage Therapy Treatment. I authorize the release of my medical information for the purposes of billing. I also authorize and allow the payments to be sent directly to Belange Body Care.

____

Signature

Or

Name of Patient: ____

____

Signature of Guardian

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