

# Belanger Body Care

4630 200<sup>th</sup> Street S.W Suite M.  
Lynnwood, Washington 98036

## Client File Intake Form – Private Pay

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Office: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Name of Spouse: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic: \_\_\_\_\_

Other Professionals Seen: \_\_\_\_\_

How Often: \_\_\_\_\_

In your own words please describe why you are here today;

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Are you taking any medications? Yes \_\_\_ No \_\_\_

Details: \_\_\_\_\_

**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