

Belanger Body Care

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

Client File Intake Form – Work 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: _____

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: _____

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