

Queen Anne Natural Health

Significant Trauma (auto accidents, falls, etc./dates):	
Past Medical Problems (type and date):	
Surgeries (type of and date):	
Date that you last visited a medical doctor?	Reason for visit:
Comments: (please describe any other issue(s) you would like to discuss):	

General: (Please check all that are or have been applicable to you - if past, indicate age or date.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Tremors | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Unusual Fatigue | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Swelling of the feet/legs | <input type="checkbox"/> Phlebitis/varicose veins |
| <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of the hands/arms |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Concussion/brain injury | <input type="checkbox"/> Bad temper/easily angered | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Depression | <input type="checkbox"/> Stressed easily |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/wrist pain |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Recurrent sprains/injuries | <input type="checkbox"/> Wound/injury | |

Other: _____

I, _____, hereby authorize **my licensed massage therapist at Queen Anne Natural Health** to provide me with massage therapy. I voluntarily consent to receiving therapeutic massage, realizing that no guarantees have been given to me by my practitioner regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have clearly stated all of my known health issues, and agree to keep my practitioner updated and informed about any health changes that may occur. ***If you are pregnant, have a bleeding disorder, pacemaker or any active infections you must make that information known to your practitioner prior to treatment.**

I agree to give **24-hour cancellation notice** for any appointment or pay the full treatment fee. **Please Initial** _____

Signature of Patient, Representative, or Guardian

Date

600 West McGraw Street #1, Seattle, WA 98119

www.QueenAnneNaturalHealth.com

206-282-5386

Queen Anne Natural Health

Insurance Registration Form

Name: _____ Date: _____

Email Address: _____ Cell #: _____

Address: _____ Zip: _____

Home Phone #: _____ Work #: _____ Employer: _____

Social Security # _____ Date of Birth _____

Insurance Group: _____ Member ID#: _____

Group ID #: _____ Contact #: _____

Relationship to insured _____ Sex: M/F _____ Single ___ Married ___ Other ___

Insured's Name & Date of Birth (if other than self) _____

Referring Physician: _____ Dx. Code: _____

Emergency Contact: _____ Cell #: _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the provider listed below. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature: _____ Date: _____