FULL CIRCLE

# INSURANCE HISTORY

Treatment by Kim Orte, LMP

Name ______________________ Nickname ______________ Date ______________

Address ______________________ Email ______________________

City, State and Zip Code ______________________ Date of Birth ____/____/____

Day Phone ( ) ______________ Eve Phone ( ) ______________ Cell ( ) ______________

Emergency Contact ( ) ______________ What is your relationship to this person? ______________

Employer ______________________ Occupation ______________________

Social Security Number ______________ Referring Physician ______________________

Primary Care Physician ______________ Primary Physician Phone ( ) ______________

Was injury a result of an accident? ________ Job related ☐ Auto ☐ Other ☐ Date of injury/onset ______________

Insurance Company ______________________ Group/Claim/ID # ______________

Insurance Billing Address ______________________________________________

Phone Number ( ) ______________ Contact person/case manager ______________________

Name of Insured ______________ What is your relationship to this person? ______________

Insured's Address ______________________________________________

Attorney Name (if applicable) ______________________________________________

Address ______________________ Email ______________________

City, State and Zip Code ______________________ Phone Number ( ) ______________

- I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
- I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.
- I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.
- I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
- I agree to provide 24 hour cancellation notice. If I fail to do so, I agree to pay 50% of the appointment fee. (Please note that insurance companies do not pay this, you do.)

Signature ______________________________________ Date ______________

FULL CIRCLE **HEALTH HISTORY** Treatment by Kim Orte, LMP

Check any or all that apply to your present health:

- [ ] headaches
- [ ] chronic pain
- [ ] varicose veins
- [ ] vision problems
- [ ] muscle or joint pain
- [ ] numbness/tingling
- [ ] blood clots
- [ ] sinus problems
- [ ] numbness/tingling
- [ ] HBP
- [ ] LBP
- [ ] pain/teeth grinding
- [ ] sprains/strains
- [ ] diabetes
- [ ] prostrate problems
- [ ] scoliosis
- [ ] fatigue
- [ ] cancer/tumors
- [ ] depression
- [ ] arthritis
- [ ] tendonitis
- [ ] infectious disease
- [ ] sleep difficulties
- [ ] skin problems
- [ ] endometriosis
- [ ] pregnant
- [ ] Painful menstruation

List all medications/herbs/vitamins & dosage ____________________

____________________

List physical activities you do regularly ____________________

____________________

What movements or activities are limited? ____________________

____________________

Describe the events of the injury/accident ____________________

____________________

____________________

List previous major injuries/surgeries ____________________

____________________

What other treatments are you receiving and by whom

(acupuncture, physical therapy, chiropractic, naturopathic)

____________________

What seems to help the most? ____________________

____________________

What seems to aggravate the condition most? ____________________

____________________

What is your main activity at work? ☐ Phone ☐ Sitting

☐ Computer work ☐ Driving car ☐ Walking

☐ Other ____________________

What do you do to relieve stress? ____________________

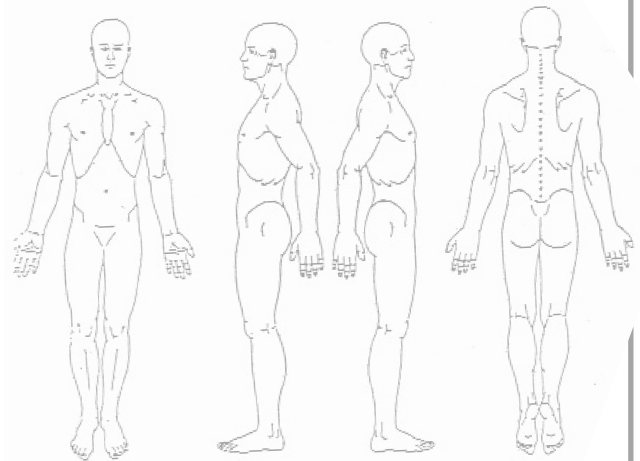
____________________

What do you want to get out of your session(s)? ____________________

____________________

____________________

On the diagrams below, please circle those areas that best correspond to the places where you feel you hold stress, tension, or those areas where you may be currently experiencing discomfort or pain:



DURING THE MASSAGE TREATMENT

1. If you notice your self unconsciously holding your breath, simply release your breath through your mouth, this enables your muscles to relax. Exhaling releases tension, while holding your breath retains tension.

2. If Kim is applying pressure or stretching a muscle, again release your breath. Your muscles will relax more easily.

3. If at any time during the treatment anything is uncomfortable, please let Kim know so she can adjust the technique to your particular need.

4. It is your responsibility to communicate any questions or concerns to Kim regarding your treatment(s).