relax therapy.

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Seattle WA 98126
Phone: 206.850.7508
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relaxtherapyseattle.com

Patient Information

Name: _____

Address: _____

City: _____

Zip: _____ **DOB**: _____

Have you had PT this year: _____

Where: _____

How did you hear about Relax Therapy:

Doctor: _____

Friend: _____

Facebook. Yelp Google

Phone#: _____

Email: _____

(your email will only be used for contact between our office and you)

How would you like to receive your appointment reminder:

- Phone call
- Text
- Email
- No Reminder

Emergency Contact: _____

Relation to you: _____

Emergency Phone#: _____

Parent/Guardian: _____

(if under 18)

HIPPA Privacy Policy

By initialing below you agree that you were given an opportunity to review and question our privacy policy. A hard copy of our policy is available at any time upon verbal or written request. Our policy is to protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered or coordinate/facilitate/expedite your care with another healthcare provider. You may request in writing for us not to release information without penalty or disruption in care at Relax Therapy. If you request restrictions on payment for services, you will be solely responsible for your account balance at time of service and you can bill your insurance company independently.

Patient or Guardian Initials: _____

Insurance/Payment Agreement

I authorize treatment and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize Relax Therapy to release any information to referring or consulting healthcare providers that may be necessary to administer care. I hereby authorize my insurance benefits to be paid directly to Relax Therapy. I certify that a copy or fax of this agreement shall be valid as the original.

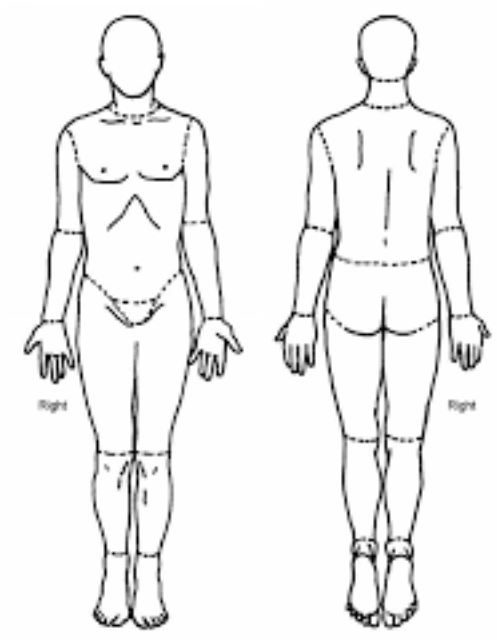
Patient/Guardian signature: _____ Date: _____

How would you like to receive your billing statement?
(check all that apply)

☐ Mail

☐ Email

Please indicate where you have pain and/or symptoms:



When did this issue begin: _____

_____

Describe the history of this problem (i.e. how did it occur?):

_____

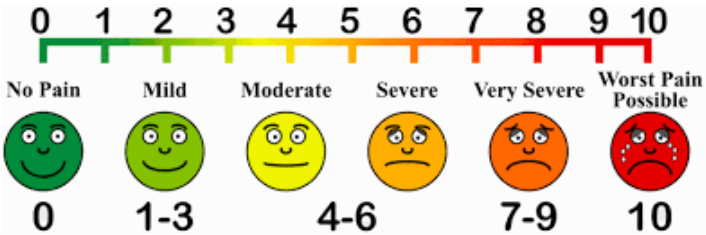
_____

_____

How would you describe your symptoms?
(select all that apply)

- Sharp
- Dull
- Numbness
- Tingling
- Other: _____
- Throbbing
- Shooting
- Aching
- Burning

Please indicate the average intensity of your symptoms:



Does your pain ever wake you up at night:

☐ Yes
☐ No

Occupation: _____

Height: _____ Weight: _____

What is your current living situation:

☐ Live alone
☐ Live with family/friends
☐ Single level/no stairs
☐ Multiple level/stairs

Due to my injury, I hurt when I (activity):

_____

_____

_____

What relieves your symptoms:

_____

_____

_____

Since your symptoms began, have you had any of the following:

- Bowel/bladder issues
- Bodily discomfort
- Weakness
- Fever/sweat/chills
- Significant weight change
- Numbness or tingling
- Pain at night
- Dizziness/fainting
- Difficulty swallowing
- Hearing/vision problems

Have you had any previous treatment or tests for this condition (i.e., physical therapy, MRI, acupuncture?)

_____

_____

_____

Please list any current medications, including over the counter and supplements:

_____

_____

_____

Please list any previous surgeries:

_____

_____

Do you currently have or have you had a history of any other medical conditions (i.e., cancer, currently pregnant, headaches, depression, stroke, kidney problems, etc.):

_____

_____

_____