Live By Massage Auto Injury Intake

Name_____Date of Birth_____

Address_____

Phone_____ Is it OK to call for special offers/updates? __Yes __No

Email_____Is it OK to send special offers/updates? __Y __N

Emergency Contact Name_____Phone_____

P.I.P. Carrier_____ Name of Insured_____

Date of Accident_____ Claim #_____

Claim Representative_____ Phone _____

Attorney _____ Phone _____

How'd you hear about us?

- ☐ Friend/Family
- ☐ Ad
- ☐ Internet search
- ☐ Coupon/Special offer
- ☐ Chair massage at event
- ☐ Other_____

Medical History and Information Check any or all that apply to your present health:

- ☐ Headaches
- ☐ Chronic pain
- ☐ Varicose veins
- ☐ Vision problems
- ☐ Muscle or joint pain
- ☐ Blood clots
- ☐ Sinus problems
- ☐ Numbness/tingling
- ☐ Diabetes
- ☐ High/low blood pressure
- ☐ Sprains/strains
- ☐ Anxiety
- ☐ Fatigue
- ☐ Scoliosis
- ☐ Cancer/tumors
- ☐ Liver/kidney problems
- ☐ Depression
- ☐ Arthritis
- ☐ Infectious disease
- ☐ Sleep difficulties
- ☐ Tendonitis
- ☐ Skin problems
- ☐ Jaw pain
- ☐ Teeth grinding

Women only:

- ☐ Pregnant
- ☐ Painful menstruation
- ☐ Endometriosis

Men only:

- ☐ Prostrate problems
- ☐ Other(Please explain):

_____

_____

_____

_____

_____

Were you (circle one): Driver Front passenger Rear left passenger Rear right passenger

Number of people in your vehicle _____ Were you wearing your seatbelt _____

Did you go to the emergency room? _____ Which Hospital?_____

Did any part of your body strike anything in the vehicle? (explain): _____

_____

What did your vehicle impact? _____

Did the impact to your vehicle come from (circle one): Front Back Right Left Other

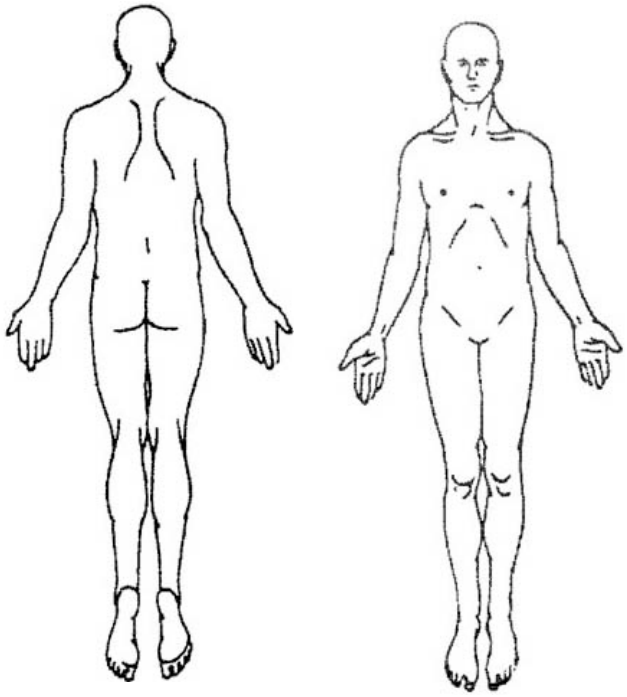
In your own words, please describe the accident: _____

_____

_____

Please circle all injured areas. Specify where you are feeling the following symptoms?

A=Ache B=Burning N=Numbness P=Needles S=Stabbing R=Shooting Pain



Please rate your pain level - choose the number which best describes your pain:

(0=No pain 10=Unbearable)

Neck	0	1	2	3	4	5	6	7	8	9	10	at its worst
Upper back	0	1	2	3	4	5	6	7	8	9	10	at its worst
Lower back	0	1	2	3	4	5	6	7	8	9	10	at its worst

Do you have headaches? _____How often?_____How long do they last?_____

List previous injuries/major illnesses and approximate date: _____

_____

What seems to help the most? _____

What seems to aggravate the condition most? _____

What is your main activity at work? _____

What physical activities you participate in regularly? _____

What other repetitive activities? _____

What do you do to relieve stress? _____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic)?

_____

_____

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 with the understanding that the third missed appointment will be paid in full to Live By Massage.

Signature _____Date_____