PATIENT INTAKE
MOVEMENT INTELLIGENCE

__VASHON 19001 VASHON HWY SW 98070 __SEATTLE 600 FIRST AVE #418 98104

PATIENT NAME______________________________ DATE OF BIRTH: __________ DATE: ___________

PERSONAL CONTACTS

Please ☑ preferred contact methods

☐ Email: ______________________________

☐ Phones: ____________________ hm/mob/wk

____________________ hm/mob/wk

Do you text? ☐ YES ☐ NO

Mailing Address:______________________________

City:__________________ Zip:__________

What is your occupation? ______________________

Emergency Contact Name: ______________________

Phone:____________________ hm/mob/wk

Relationship:____________________

HEALTH CARE INSURANCE & PROVIDER

Insurance Name: ______________________________

I.D.# or Claim#: ______________________________

Insurance type:

☐ Individual ☐ Employer

Employer Name: ______________________________

Employer Address:______________________________

City:______________ Zip:____________

☐ Vehicle Accident: Date of Injury: ____________

Name of Attorney:______________________________

Phone:__________________

Primary Provider Name: ________________________

Practitioner is a: ☐ M.D. ☐ N.D. ☐ Other: ____________

Address/City: ______________________________

Phone: ______________________________

CURRENT VISIT

What health concerns prompt your visit? Please ☑:

☐ General wellness/maintenance (I do not have pain today).

My session preferences are: ____________________

☐ Concerns with no specific incident (cause unknown or repetitive)

☐ Concerns with specific injury/incident, Date: ____________

Please detail your health concerns.

Primary concern: ______________________________

Treatment: ______________________________

Symptoms seem to be (please ☑ all that apply in each column):

☐ Mild	☐ Constant	☐ Increased w/activity	☐ Getting better
☐ Moderate	☐ Sporadic		☐ Not changing
☐ Disabling	☐ Predictable	☐ Decreased w/activity	☐ Getting worse

My condition affects my daily:

☐ Work life ☐ Home/family life ☐ Sleep ☐ Recreational or social life

Secondary concern: ______________________________

Treatment: ______________________________

Symptoms seem to be (please ☑ all that apply in each column):

☐ Mild	☐ Constant	☐ Increased w/activity	☐ Getting better
☐ Moderate	☐ Sporadic		☐ Not changing
☐ Disabling	☐ Predictable	☐ Decreased w/activity	☐ Getting worse

My condition affects my daily:

☐ Work life ☐ Home/family life ☐ Sleep ☐ Recreational or social life

HEALTH HISTORY

Please list the following- Surgeries (include type and date):

____

____

Injuries:

____

____

Major illnesses:

____

____

SELF CARE

Have you received massage therapy before today? ☐ Yes ☐ No

How often? ______times per _______

How do you…

Reduce stress?

____

Reduce pain?

____

Please list current medications (include pain relievers and herbals):

____

____

Additional concerns: ______________________________

____

		Please check current/previous conditions.
now	past	GENERAL
		Pain
		Sleep disturbance
		fatigue
		infections
		fever
		sinus
		other
		SKIN CONDITIONS
		Rashes
		Athlete's foot, warts
		other
		MUSCLES AND JOINTS
		rheumatoid arthritis
		osteoarthritis
		scoliosis
		broken bones
		spinal problems
		disk problems
		lupus
		TMJ, jaw pain
		spasms, cramps
		sprains, strains
		tendonitis, bursitis
		stiff or painful joints
		weak or sore muscles
		neck, shoulder, arm pain
		low back, hip, leg pain
		other:
		NERVOUS SYSTEM
		head injury, concussions
		dizziness, ringing ears
		memory loss, confusion
		numbness, tingling
		sciatica, shooting pain
		chronic pain
		depresson
		other
		RESPIRATORY & CARDIOVASCULAR
		heart disease
		Blood clots
		stroke

		Condition and Comments
now	past	RESPIRATORY & CARDIOVASCULAR
		blood clots
		stroke
		lymphadema
		high, low blood pressure
		irregular heartbeat
		poor circulation
		swollen ankles
		varicose veins
		chest pain, short breaths
		asthma
		ALLERGIES
		scents, oils, lotions
		detergents
		other:
		DIGESTIVE SYSTEM
		bowel problems
		gas, bloating
		bladder/kidney/prostrate
		abdominal pain
		other:
		ENDOCRINE SYSTEM
		thyroid
		diabetes
		REPRODUCTIVE SYSTEM
		pregnancy
		painful, emotional menses
		fibrotic cysts
		CANCER/TUMORS
		benign
		malignant
		HABITS
		tobacco
		alcohol
		drugs
		coffee, soda

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Movement Intelligence Policies

Appointment Policy
Please call, text, or cancel/reschedule online at least 24 hours in advance. When you fail to notify us, we are left with openings appointment times that could otherwise be used to help someone else and you will be responsible for any late cancel or no show charges. Please help us help others.

Privacy Practices
I understand that some of my health information may be used and/or disclosed by Hallie Aldrich / Movement Intelligence to carryout treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the office's privacy notice entitled "Our Privacy Practices". I understand that I may review this policy notice at any time prior to signing this form.

I understand that over time, the office policy may change in accordance to the law and that if I wish to obtain a copy of the notice as revised, I can notify the office and request such a copy.

Consent to Treatment
I hereby request and consent to the performance of massage and somatic education procedures by Hallie Aldrich, LMP and/or licensed LMPs and somatic educators who may practice in or be contracted with Hallie Aldrich / Movement Intelligence.

I have read the above or have had it read to me. I am comfortable with the information provided. I consent to massage treatment and management on this basis.

Signature:_______________________________________Date:________________