

# Benessere Chiropractic, Massage and Fitness, LLC

295 W. Broadway

Eugene, OR 97401

Ph: (541) 636-3358 F: (541) 636-3098

## Patient Registration

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ email \_\_\_\_\_  
M\_\_ F\_\_ Preferred Gender designation: \_\_\_\_\_  
Marital Status: S M W D P Spouse's Name \_\_\_\_\_ # of children \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
I am here today due to: \_\_Illness \_\_Trauma \_\_Work Injury \_\_Auto Crash \_\_Other  
Date of the injury? \_\_\_\_\_

Personal Insurance Company: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ ID No: \_\_\_\_\_  
Group No: \_\_\_\_\_ Claim No: \_\_\_\_\_ Medicare No: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ ID No: \_\_\_\_\_  
Group No: \_\_\_\_\_ Claim No: \_\_\_\_\_ Medicare No: \_\_\_\_\_

### Agreement

I understand that my Insurance policy is a contract between my insurance carrier and myself. Benessere Chiropractic, Massage and Fitness, LLC (Benessere) will bill my Insurance Company as a courtesy and does not guarantee payment by my Insurance Company. I agree that I am personally responsible for all the services rendered to me by the practitioners at Benessere.

I authorize the release of any prior medical information necessary to be properly evaluated by Chiropractors at Benessere and to assist in the processing of my insurance claim. I authorize my Insurance Company to send payments for services rendered directly to Benessere.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Massage Client Intake

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Occupation : \_\_\_\_\_ Referred by: \_\_\_\_\_  
Have you ever had massage before?  No  Yes, likes/dislikes:

What are you looking to get from massage (relaxation, tension relief, injury rehabilitation/prevention, etc.):

Is there any area on which you would like extra work? Any area which is frequently tense or painful?

Do you have any repetitive motion or stress from your job?

Do you participate in a sport or form of exercise? If so, what kind of activity and how often?

Are you under a physicians care or have you recently been ill, injured, or hospitalized. If so, please explain in detail: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have allergies to or intolerance of:  
 Nut oils  Lotions  Fragrances  
Explain: \_\_\_\_\_

Do you have any skin sensitivities or conditions?  No  Yes \_\_\_\_\_

\_\_\_\_\_

Do you have any blood circulation problems?  No  
 Yes:  Varicose Veins  Blood Clotting Disorder  Bruise Easily  
 Blood Thinning Medications \_\_\_\_\_  
 Heart Disease \_\_\_\_\_

List all Medications and reason for taking them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## First Priority for Treatment

Body region: \_\_\_\_\_

When did symptoms first start? \_\_\_\_\_

What makes the symptom(s) better? \_\_\_\_\_

What make the symptom(s) worse? \_\_\_\_\_

Symptoms worse in the:  Morning  Evening  Unaffected by time of day  
 Worse in the morning then better mid day then gets worse in evening  
 Constant through the day  Worse on days that you go to work?

Describe quality/type of symptoms:

Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing

Other: \_\_\_\_\_

Do symptoms radiate to arms, legs or into your head? (Describe in detail)

\_\_\_\_\_

Describe the quality / type of radiation:

Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 \_\_\_\_\_ 10 (Worst pain/ brings you to tears)

Treatment for this symptom in the past:  No  Yes where? \_\_\_\_\_

Treatment for symptoms in this area any time before in your life:

Where? \_\_\_\_\_

When? \_\_\_\_\_

Response to prior treatment: \_\_\_\_\_

Type of prior treatment: \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

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## Second Priority for Treatment

Body region: \_\_\_\_\_

When did symptoms first start? \_\_\_\_\_

What makes the symptom(s) better? \_\_\_\_\_

What make the symptom(s) worse? \_\_\_\_\_

Symptoms worse in the:  Morning  Evening  Unaffected by time of day  
 Worse in the morning then better mid day then gets worse in evening  
 Constant through the day  Worse on days that you go to work?

Describe quality/type of symptoms:

Dull ache / Tightness / Stiffness / Sharp / Burning / Brief Twinges / Throbbing

Other: \_\_\_\_\_

Do symptoms radiate to arms, legs or into your head? (Describe in detail)

\_\_\_\_\_

Describe the quality / type of radiation:

Tingle / Numbness / Deep Ache / Burning / Skin Crawling / Sharp

Rate severity of the symptom by placing an X on the line below:

(No pain) 0 \_\_\_\_\_ 10 (Worst pain/ brings you to tears)

Treatment for this symptom in the past:  No  Yes where? \_\_\_\_\_

Treatment for symptoms in this area any time before in your life:

Where? \_\_\_\_\_

When? \_\_\_\_\_

Response to prior treatment: \_\_\_\_\_

Type of prior treatment: \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

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## Past Health History

Have you ever had Massage Therapy?  No  Yes (names):

Reason for treatment: \_\_\_\_\_

Response to treatment: \_\_\_\_\_

Techniques used: \_\_\_\_\_

Do you take vitamins or minerals?  No  Yes

Please list: \_\_\_\_\_

Please list all medications: \_\_\_\_\_

Have you had any X-Ray, MRI, CT scans in the past 10 years?  No  Yes

Date	Test	Body Region	Doctor/Testing Center
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_____	_____	_____	_____
_____	_____	_____	_____

Have you ever broken/fractured a bone?

Date:	Bone/Region:	Treatment	Completely Healed?
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_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes

Have you ever been involved in a car crash?

Date:	Description:	Injuries:	Resolved:
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_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes
_____	_____	_____	[ ] No [ ] Yes

Please list all surgeries or major illnesses.

Date:	Description:	Resolved:
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_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes

Other injuries (falls, concussions, trauma):

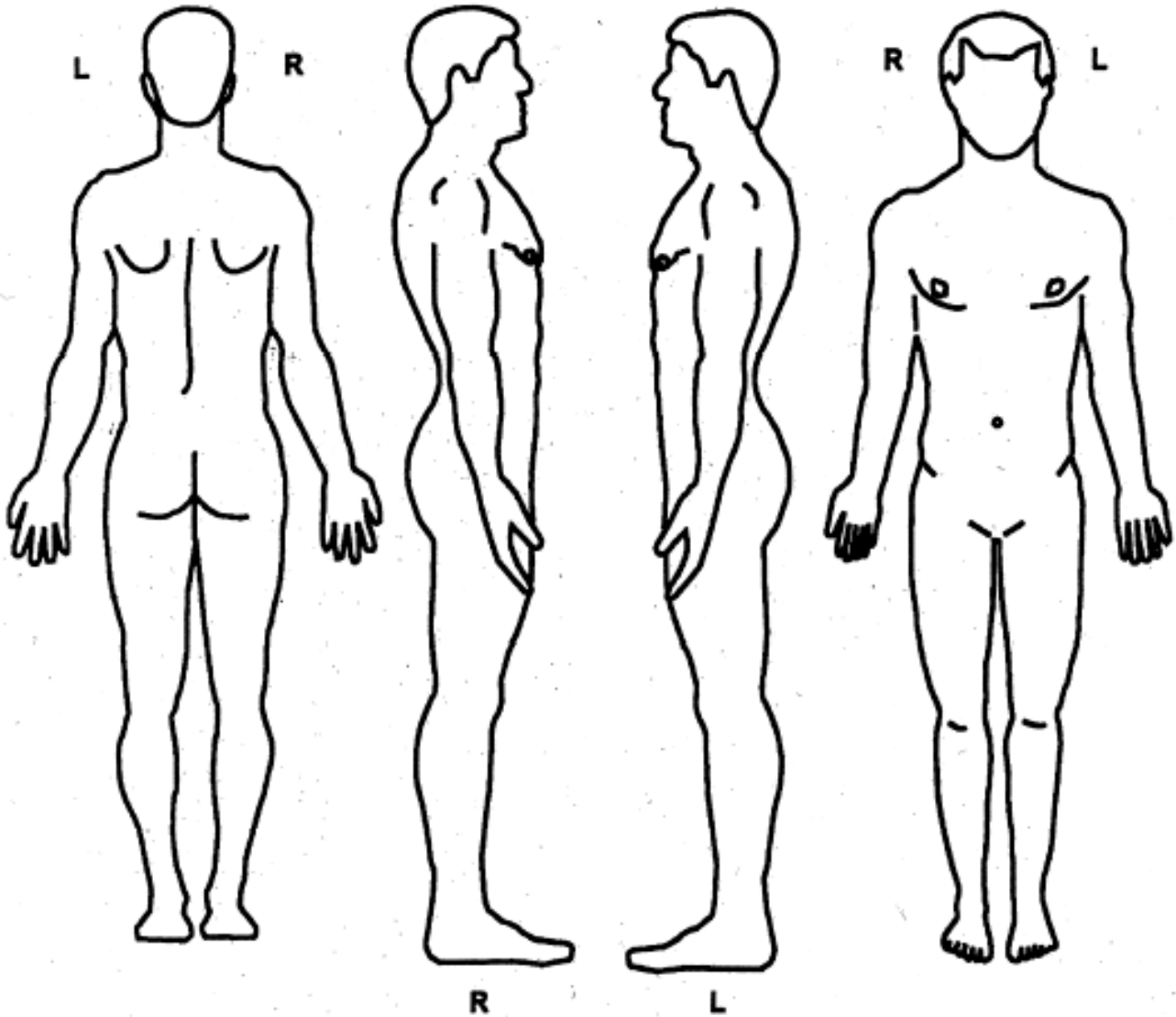
Date:	Description:	Resolved:
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_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes
_____	_____	[ ] No [ ] Yes

	Heavy	Moderate	Light	None	Do you wear?
Alcohol	[ ]	[ ]	[ ]	[ ]	[ ] Orthotics
Tobacco	[ ]	[ ]	[ ]	[ ]	[ ] Heel lifts
Coffee	[ ]	[ ]	[ ]	[ ]	[ ] Insoles
Exercise	[ ]	[ ]	[ ]	[ ]	[ ] Arch supports
Sleep	[ ]	[ ]	[ ]	[ ]	

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## Pain Drawing



Mark as follows:

A = Ache    B = Burning    N = Numbness    P = Pins & Needles / Tingle    S = Stabbing

O = Other, describe \_\_\_\_\_

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## Payment Policy

We require payment at the time of service. If you have private health insurance we ask that you pay your co-pay or co-insurance at the time of service. If you have a yearly deductible, you must meet that as your policy specifies. We may or may not bill, or you may bill, your insurance company. If payment for any part of your treatment is denied by your insurance carrier you will assume full responsibility for payment and will pay independent of any appeal process with the insurance carrier.

In the case of either personal injury, auto accident, or workers' compensation claims, we will bill the entire amount of each visit to your insurance company. The cost of supplies, supports and/or supplements not paid for by your insurance company is your responsibility.

If you have any questions concerning our payment policy, please feel free to ask the receptionist.

## Cancellation Policy

We require 24 hours notice for all cancellations. If you cancel with less than 24 hours notice, you will be charged 50% of the total charges for the scheduled visit. If you fail to attend your appointment and do not call to cancel, you will be charge IN FULL for the total visit. We send reminder texts as a courtesy. It is your responsibility to be on time for your appointments.

I have read and understood the above payment and cancellation policies and agree to follow them while utilizing the services at Benessere Chiropractic Massage and Fitness, LLC.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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