



tactus
massage therapies

1828 NW OVERTON ST.
PORTLAND OR 97209
503-750-2804
mail@tactusmassage.com

PATIENT INTAKE FORM

Please complete all sections completely and thoroughly. Thank you.

SECTION A GENERAL INFORMATION

Name: _____ Date: _____
 DOB: _____ ODL#/State: _____ SSN: _____
 Current Address: _____ Apt. _____
 City: _____ State: _____ Zip: _____
 Email: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____ Message Phone: _____
 Occupation: _____ Title: _____
 Employer: _____

SECTION B LOCAL EMERGENCY CONTACT

In case of emergency, please contact: _____
 Phone: _____ Relation to self: _____

SECTION C PRIMARY CARE PROVIDERS

Referring Physician: _____
 Clinic: _____ Phone: _____
 Other Current Physician: _____
 Clinic: _____ Phone: _____
 Other Current Physician: _____
 Clinic: _____ Phone: _____
 Do we have permission to contact these physicians if medically necessary? Yes No
 Do we have permission to send treatment related reports to these physicians? Yes No

SECTION D
INSURANCE INFORMATION

INSURANCE COMPANY

Company Name: _____ Plan Name: _____

Adjuster Name: _____ Phone: _____

Claims Office Address: _____

City: _____ State: _____ Zip: _____

Claim #: _____ Policy/Group #: _____

PRIMARY POLICY HOLDER

PPH is patient, information is the same as above (continue to Section E)

Patient's Relation to PPH: Spouse Child Other: _____

Name (as stated on policy) _____

SSN: _____ DOB: _____ Phone: _____

Current Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Message Phone: _____

GENERAL BILLING INFORMATION

Sex: Male Female

Marital Status: Single Married Separated Divorced Widowed

Employment: Full-time Part-time Self Retired Unemployed

Student: Full-time Part-time

Do we have permission to bill your insurance on your behalf? Yes No

Do we have permission to release all appropriate case related documents to your insurance adjuster for billing related purposes? Yes No

ATTORNEY (in case of litigation)

Name: _____ Firm: _____

Address: _____ Ste. _____

City: _____ State: _____ Zip: _____

Phone: _____ Message Phone: _____

SECTION E
CAUSE OF INJURY

Is your condition related to an accident? Yes (please complete) No (continue to Section F)

What type of accident? Auto Work Personal injury

Was a police report filed for this accident? Yes No

When did the accident occur? _____

What state did the accident occur? _____

SECTION F
GENERAL MEDICAL HISTORY

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing any medical devices? If yes, what type? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from any of the following skin disorders? <input type="checkbox"/> Rash <input type="checkbox"/> Yeast <input type="checkbox"/> Fungus <input type="checkbox"/> Psoriasis <input type="checkbox"/> Brittle skin <input type="checkbox"/> Basel Cell Carcinoma <input type="checkbox"/> Virus <input type="checkbox"/> Bacteria <input type="checkbox"/> Cancer <input type="checkbox"/> Other:_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from any of the following allergies? <input type="checkbox"/> Oils <input type="checkbox"/> Nuts <input type="checkbox"/> Detergents <input type="checkbox"/> Perfumes <input type="checkbox"/> Skin care ingredient(s) <input type="checkbox"/> Other:_____
		If so, please list and describe symptoms of allergy:_____

<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under the care of a physician for any reason? If yes, please explain the condition and treatment:_____

<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medications? If yes, what kind and when was your last dosage?_____

<input type="checkbox"/>	<input type="checkbox"/>	Have you had any recent illnesses? If yes, what and when? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you sick now? If yes, with what and how do you feel?_____

<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with any of the following conditions? <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Aneurism <input type="checkbox"/> Embolism <input type="checkbox"/> Heart disease <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Diabetes type I <input type="checkbox"/> Diabetes type II (adult onset) <input type="checkbox"/> Cancer (type and location(s)):_____
		<input type="checkbox"/> Scoliosis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fractures <input type="checkbox"/> Dislocations <input type="checkbox"/> Other:_____
YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery? If yes, when and what type?_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any needs that require special attention?_____

<input type="checkbox"/>	<input type="checkbox"/>	Do you have any concerns about your injury or this type of treatment?_____

