

# REVERIE

## Therapeutics

boutique and day spa

### Client Intake Form

Account # \_\_\_\_\_

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
(Legal last) (First) (Middle)

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Female: Pregnant  Yes or No

Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_  
(Number & Street) (City) (State) (Zip)

Personal Physician \_\_\_\_\_

Address \_\_\_\_\_  
(Number & Street) (City) (State) (Zip)

Phone (\_\_\_\_) \_\_\_\_\_ Referred By \_\_\_\_\_

In Case of Emergency Contact \_\_\_\_\_  
(Name and Phone Number)

Have you ever had massage therapy before?  Yes or No  If yes, what type and how often \_\_\_\_\_

Reason for today's visit and desired results: \_\_\_\_\_

**Mark diagram with an X to identify symptom areas:**

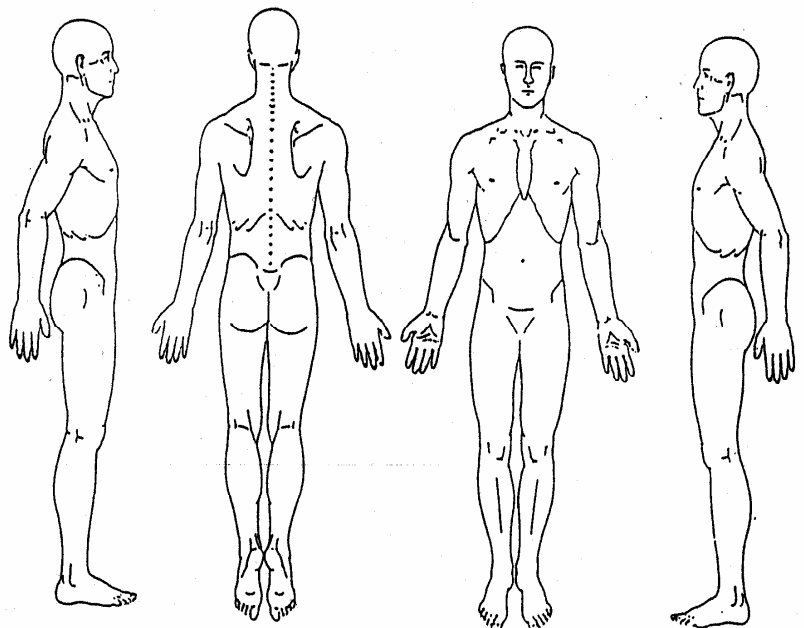
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Rate severity of all symptom areas from 1 – 10:**  
Minimum 1 2 3 4 5 6 7 8 9 10 Maximum

**History:**  
Surgeries: \_\_\_\_\_

Accidents: \_\_\_\_\_

Major Illnesses: \_\_\_\_\_



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### Current Health:

Are you under the care of a physician?  Yes or No

If yes, Please explain: \_\_\_\_\_

Are you taking any prescription, over-the-counter, or herbal remedies?  Yes or No

If yes, Please explain: \_\_\_\_\_

Check any of the following that apply to your current health:

High Blood Pressure

Blood Clots

Arthritis

Diabetes

HIV/AIDS

Artificial Bones/Joints/Valves

Heart Condition

Circulatory Conditions

Asthma

Cancer

Varicose Veins

Allergies/Sensitivities

Comments: \_\_\_\_\_

Any additional information regarding your health: \_\_\_\_\_

### Insurance Information:

Medicare# \_\_\_\_\_ Medicaid# \_\_\_\_\_ ( ) Self Pay

( ) Worker's Compensation - Claim # \_\_\_\_\_ Carrier

Primary Insurance: (If other than above) Name & Address \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Certificate# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance: Name & Address \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Certificate# \_\_\_\_\_ Group# \_\_\_\_\_

### I plan to make payment of my expenses as follows: (Check one)

( ) Cash/Check ( ) MasterCard/Visa ( ) American Express ( ) Other arrangements to be made with the Business Office

### RELEASE OF INFORMATION - FINANCIAL AGREEMENT - ASSIGNMENT OF INSURANCE

I hereby authorize my insurance company, and/or other concerned third party to make payment directly to Reverie Therapeutics.

I authorize Reverie Therapeutics release to my insurance company or other concerned third party, any medical information needed to process my claim.

In addition, I understand that I am responsible for all charges incurred regardless of insurance or third party liability. In the event that my account is not paid in full within sixty (60) days from the date of service, an interest fee at the rate of 3% per month will be charged, with a \$1.00 minimum.

Date \_\_\_\_\_ Signature \_\_\_\_\_

(Responsible Party)

520 Main Street Covington, Ky. 41011

Phone 859.261.5444