

West Chester Acupuncture and Chiropractic

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. - Dr. Burton Young, DC, FIAMA, Dipl.Ac.
7665 Monarch Ct. Suit 110 West Chester OH, 45069 - 513-77-9428

Medical Intake Form For Massage

Date: _____

Please take a moment to complete the following questionnaire. This will help to ensure a safe and comfortable massage session for you. All information is confidential.

Have you received massage in this office in the past? () Yes () No If yes, please inform the therapist before continuing.

Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

E-mail: _____

Emergency Contact: _____

Relationship to you: _____ Phone #: _____

PCP: _____ Phone #: _____

Do you give permission to contact your Physician: () Yes () No

Have you ever had a massage before: () Yes () No If yes, when? _____

Do you smoke? () Yes () No Do you consume alcohol? () Yes () No

Do you have any areas that you want specific attention? _____

Do you have allergies to any skin oils, lotions or fragrances: () Yes () No If yes, explain? _____

Are you currently taking any blood thinners?

Coumadin Lovenox Heparin Any Pain Medication: _____

Are you taking any cancer medication? () Yes () No

If yes, please list: _____

Are you taking any muscle relaxants? () Yes () No

If yes, please list: _____

Have you taken any medications in the last 24 hours? () Yes () No

If yes, please list: _____

Have you had surgery within the last 5 years? () Yes () No

If yes, what & when: _____

Have you had any implants within the last 9 months? () Yes () No

If yes, what & when: _____

Do you currently have any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Acute inflammatory conditions (ex. Phlebitis or Cellulites) | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Arthritis/ Tendonitis
(Stenosis, Spondylitis or Spondylolisthesis) | <input type="checkbox"/> Injections recently at joint or muscle junctures |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Injuries – list below type and when |
| <input type="checkbox"/> Blood thinners (Coumadin, Heperin, Aspirin 325mg/ day) | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Breast implants within last 9 months | <input type="checkbox"/> Joint surgery, joint replacement (ex. Steel rods) |
| <input type="checkbox"/> Broken/cracked ribs | <input type="checkbox"/> Kidney or Liver disorder (including Dialysis) |
| <input type="checkbox"/> Cancer - list below type, benign or active | <input type="checkbox"/> Neck/back injuries |
| <input type="checkbox"/> Chemotherapy or radiation therapy | <input type="checkbox"/> Neuropathy (from disease or chemo) |
| <input type="checkbox"/> Depressed immune system (Lupus, Epstein, Barr, Mononucleosis, HIV/AIDS) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes (Insulin pump? Yes or No) | <input type="checkbox"/> Pacemaker/heart conditions |
| <input type="checkbox"/> Dialysis (need MD's written permission) | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Skin – boils, skin lesions or abscesses, psoriasis, acute conditions, acne, skin cancer, shingles, burns, eczema, recent surgery by dermatologist – list below |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sprains/strains |
| <input type="checkbox"/> Fractures/dislocations- list below type and when | <input type="checkbox"/> Surgery – list below any recent surgeries |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> TMJ dysfunction |
| <input type="checkbox"/> Herniated or protruded discs (Area: _____) | <input type="checkbox"/> Tuberculosis, Thrombosis or Aneurysm (circle) |
| | <input type="checkbox"/> Varicose veins |

Note: Clients who have undergone any surgery including Lasik eye surgery must avoid massage for 72 hours. Massage must be avoided by anyone who has consumed alcohol within 24 hours of appointment. If you have had a heart condition that required surgery, pacemaker, stint or shunt you will need to avoid massage for one year and you will need written approval from your surgeon in the form of a permission slip.

List any necessary details or additional information the therapist may need to know.

*Please note, if we may be of any assistance with chiropractic care, please do not hesitate to schedule an appointment. There is no charge for a consultation. This allows you time to speak with the doctor about your health concerns. If you are currently receiving chiropractic care, some insurance companies cover massage therapy if recommended by the doctor.

Massage Therapy Informed Consent

I, _____, understand that the massage therapy provided by the licensed massage therapist is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that the massage therapy is not a substitute for medical diagnosis, medical treatment or medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions, and medications and I will keep the massage therapist updated on any changes. I give my consent to receive the treatment.

Client Signature

Date

Welcome to West Chester Acupuncture and Chiropractic

2020 Massage Therapy Payment Agreement

Our office will verify your insurance benefits as a courtesy for you. However, a verification of benefits is never a guarantee of payment from the insurance company. For this reason, our office needs patients to sign a payment agreement to guarantee payment for their services. If for any reasons your insurance does not cover the services rendered, then you will be financially responsible for the entire amount owed to Dr. Hilbert, and/or Dr. Young.

In addition our office requires a 4 hour cancellation notice for all massage services or a fee will occur.

You must call or leave a message at the office at least 4 hours prior to your appointment to avoid a fee. You will be charged one of the according fees below on your credit card the same day that the late/missed appointment occurs. Reminder calls are done as a courtesy; you are ultimately responsible for keeping your appointment. If you are running late please call the office so that we may inform your massage therapist. There is no fee for being late however; your massage time may be cut short due to the schedule.

The fees for a missed or late cancellation of a massage are as follows:

30 Minute Massage (\$20.00) 60 Minute Massage (\$35.00) 90 Minute Massage (\$45.00)

By signing below, I agree to these terms:

Patient Signature

Date

Print Name

2020

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