# WCAC Massage Intake Form

*Our office utilizes PIN #'s to sign into your appointment. Please select a preferred PIN number of your choice:

**PIN #:** _____

**First Name** : _____ **MI**: _____ **Last Name**: _____

**Address**: _____ **City/State** : _____ **Zip**: _____

**Primary#:** (_____) _____ - _____ **Mobile#:** (_____) _____ - _____

**Birthday:** _____/_____/_____ **Gender**: ☐Male ☐Female **Marital Status**: ☐Married ☐Single ☐Widowed ☐Other

_____ (_____) _____ - _____ _____

**Emergency Contact Name** **Phone #** **Relationship**

**Employment Status**: Full Time Part Time Retired Student Other **Employer's #** (_____) _____ - _____

**Employer:** _____ **Occupation:** _____

**Areas of complaint, pain, tension or concern**: _____

## Please circle the following if it applies:

| | | | | | |
|---|---|---|---|---|---|
| Have had massages before | **Yes** | **No** | Strains/Sprains | **Yes** | **No** |
| Wear contact Lenses | **Yes** | **No** | Spinal Problems | **Yes** | **No** |
| Skin Problems or Allergies | **Yes** | **No** | Varicose Veins or Blood Clots | **Yes** | **No** |
| Arthritis | **Yes** | **No** | Heart or Circulatory Issues | **Yes** | **No** |
| Blood Pressure Issues | **Yes** | **No** | Stress | **Yes** | **No** |

Surgeries: **N/A Yes**: _____

Traumatic Falls or Injuries: **N/A Yes**: _____

Illness or Conditions: **N/A Yes**: _____

Medications/Supplements: **N/A Yes**: _____

Under care of any other Health Care/Mental Care Practitioner: **N/A Yes**: _____

Activities/Hobbies that might influence your massage: _____

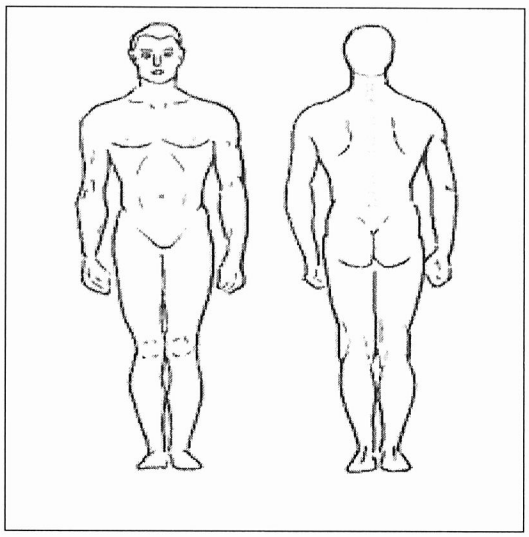
**Please mark the figures using the following keys:**

Area of Pain ○ Area of Tightness ● Area of Tenderness ×

*Note the severity of the pain using a 0-10 pain scale

1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Pain



I understand that massage therapy given here is for the purpose of stress and pain reduction, relief from fascial and/or muscular restrictions, and for increasing circulation and energy flow. I understand that the massage therapist does not diagnosis illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals or perform spinal manipulation. I understand that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see an appropriate health care provider for any physical ailment that I might have. With this in mind, I agree to receive massage therapy and hold the massage therapist harmless for any issues that might arise as a result of the massage session.

Name (Printed) _____

Signature _____ Date: _____/_____/_____

# Wentzville Chiropractic and Acupuncture Center

1023 Main Plaza Drive, Wentzville, MO 63385 (636)639-8944

**Consent to Treat a Minor for Massage Therapy**

I hereby authorize any Licensed Massage Therapist associated with WCAC to treat my

child_____

( Name of Minor)

whom in which is a minor, with full understanding of the treatment(s) in which my child will be receiving. I am signing that I am the above child's parent and/or legal guardian.

_____ _____

(Signature of Parent or Guardian) Witness's Signature

Date: _____/_____/_____

# Wentzville Chiropractic and Acupuncture Center

**Joan Brower D.C.; Daryl Ridgeway D.C.; Xephyr Day D.C.; Leah Owens D.C.; Jay Hauptman D.C.**

## CONSENT TO CHIROPRACTIC TREATMENT PLAN

### THE MATERIAL RISKS INHERENT TO YOUR TREATMENT

Chiropractic care is a safe and effective approach for many health conditions, however as with any healthcare procedures, chiropractic treatments present the risks of complications or negative side effects. The list below includes the various treatments available in our clinic and the potential risks associated with these treatments.

**CHIROPRACTIC EXAMINATION**

Prior to establishing a treatment plan the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

**CHIROPRACTIC MANIPULATION THERAPY**

The risk associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. Your doctor may recommend the use of ice packs to reduce the discomfort.

**HOT AND COLD THERAPY**

Application of a hot or cold pack can cause a local burn. We place a towel underneath the pack to minimize this risk, however if you have very sensitive skin you may experience a reaction. Please inform your doctor if the application is uncomfortable

**ULTRASOUND**

The therapeutic effect of ultrasound is produced by heat. The risk associated with ultrasound therapy is burning of tissues at the application site. Ultrasound should not be painful. If you experience pain from the treatment please inform your doctor. If you have a metallic implant in the area to be treated, inform your doctor, as the implant concentrates the heat.

**ELECTROTHERAPY**

The therapeutic electronic current is transmitted to your body via electrodes. A small defect in the electrode coating, not always detected by observation, may concentrate the current, causing a small burn to the skin. If you feel it sting where the electrode is placed, please inform your doctor. Electronic stimulation causes muscles to contract and in rare instances a muscle cramp may occur during such treatment. Inform your doctor if the procedure is uncomfortable.

**GRASTON SOFT TISSUE TECHNIQUE**

A metallic instrument is used to strip a muscle or tendon, softening adhesions and promoting healing of the injured or scared tissue. In some instances this procedure may cause bruising and some reactive swelling. This may be uncomfortable, but is not causing any harm to the patient and this reaction is part of the healing process. Please inform your doctor if you are taking blood thinner medication or if you bruise easily.

**LABORATORY TESTS**

Laboratory tests, including the collection of a blood sample may be ordered to help diagnosis your condition. Some patients may faint at the site of needles or blood. Patients with delicate veins may experience some bruising at the skin puncture site. In very rare instances the needle can touch a nerve causing pain for a few days or a few weeks.

**ACUPUNCTURE TREATMENT**

Acupuncture is a generally safe treatment, but may have some side effects including bruising, numbness, tingling, itching, and dizziness or fainting. Extremely rare risks of Acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic using sterile disposable needles and maintains a clean and safe environment.

**WATER TABLE THERAPY**

Water table therapy uses warm, jetted water to help massage and relax your muscles. May cause redness and/or an itchy sensation to the back. Temperature can get hot, please inform your doctor if it becomes uncomfortable.

**INFRARED**

Laser light therapy used for intracellular healing. Infrared is great for injuries, rashes, and many other ailments. Infrared can be harmful if used incorrectly near the eyes.

**HEAT LAMP THERAPY**

Heat lamp therapy increases circulation, loosens fascia, and accelerates the natural healing process, mainly used in conjunction with acupuncture. May cause burning if used too close to the skin.

**MASSAGE THERAPY**

Massage therapy is used to relax the muscles and tendons. May cause some bruising, temporary muscle soreness, headaches and/or dizziness.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. Please check the appropriate block and sign.** I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the clinic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest (or, in the case of a minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

| _____ | _____ | _____/_____/_____ |
|---|---|---|
| **(Patient's Name Printed)** | **(Patient or Guardian's Signature)** | **(Date Signed)** |
| _____ | _____ | _____/_____/_____ |
| **(Witness's Name Printed)** | **(Witness's Signature)** | **(Date Signed)** |

# Wentzville Chiropractic and Acupuncture Center

## Privacy Notice Acknowledgement

1. Wentzville Chiropractic and Acupuncture Center (WCAC):

   a. Is required by federal law to maintain the privacy of your PHI (Private Health Information) and to provide you with a Privacy Notice detailing the practices legal duties and privacy practices with respect to your PHI..
   b. Is required by state law to maintain a higher level of confidentially with respect to certain portions of your medical information that is provided for under federal law.
   c. Is required to abide by the terms of this privacy notice.
   d. Reserves the right to change the terms of this privacy notice and to make new privacy notice provisions affective for all of your PHI that it maintains. .
   e. Will not retaliate against you for filing a complaint.

2. Authorization: I authorize WCAC to use and or disclose information to the following person(s):

| **Name:** | **Relationship:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

☐ **I do not want any medical information released except to myself**

3. Limitations: In addition to the above, the following criteria is restricted to be released:

_____

4. Messages related to PHI: When leaving messages, I give permission to WCAC to leave a detailed message on the requested number. Please √ one or all of the following:

☐ **Home Number** ☐ **Work Number** ☐ **Cell Phone Number**

5. Voluntary Act: WCAC acknowledges that this Authorization is voluntary.

6. Revocation: I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to WCAC. However, any revocation shall not apply to the extent that WCAC has taken action in reliance on this Authorization.

7. Copy of Authorization: If WCAC has requested this Authorization from me, I understand that they will provide me with a copy of this Authorization once signed.

Name (Printed) Signature of Patient and or Guardian

Date: _____/_____/_____

# Missed Appointment Policy

Wentzville Chiropractic
1023 Main Plaza Dr.
Wentzville, MO 63385

Wentzville Chiropractic requests that you phone our office if you are going to miss an appointment so that your time can be reallocated to someone who is the need of treatment. If it is necessary to cancel your scheduled appointment we ask that you please call within 12 hours of your scheduled appointment time.

I hereby acknowledge that I will be charged a missed appointment fee if I do not call or cancel within 12 hours of my appointment time.

- Chiropractor Appointment: Fee of $25.00 for a missed appointment.
- Massage Appointment: Fee of half of the scheduled appointment time.

Signature of Patient: _____ Date: _____

**Office Use Only:**

| Doctor Notes: | Staff Notes: |
|---|---|
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