WEST END
CHIROPRACTIC & WELLNESS

MASSAGE INFORMATION & HISTORY

Please complete this form completley and
to the best of your ability.

Personal Information:

Patient Name: ____________________ Date: ____________

Date of Birth: __________ Age: ______ Sex: M or F Marital Status: S M D

Address: ________________________________

City: ____________ State: ______ Zip: ______ Email: ____________

Home Phone #: ____________ Work Phone #: ____________ Cell Phone #: ____________

Emergency Contact: ____________ Relationship: ____________ Phone #: ____________

Wellness Information:

Have you ever had a professional massage or bodywork? ☐ Yes ☐ No If so, when? ____________

Have you received Chiropractic care? ☐ Yes ☐ No Are you currently under Chiropractic Care? ☐ Yes ☐ No

Do you take time to relax? ☐ Yes ☐ No Do you feel you are under stress? ☐ Yes ☐ No

What goals / benefits do you wish to achieve from massage therapy? ____________

Are you currently physically active? ☐ Yes ☐ No What activities & how often? ____________

Injury History:

☐ Auto Accident/Year(s): ☐ Injury at Work/Year(s): ☐ Fall or Other Injury/Year(s): ☐ Sports Injury/Year(s): ____________

Please describe any injuries / conditions: ____________

How long has this condition existed? ____________ Have you had this condition in the past? ____________

Medical Information:

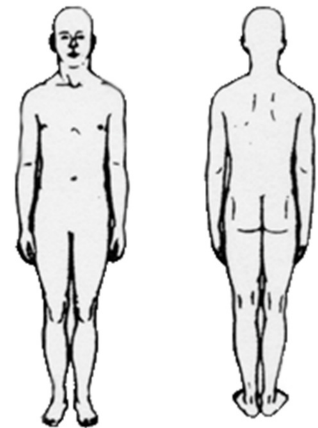
Are you currently taking medication? ☐ Yes ☐ No Types: ____________

Do you have any allergies? ☐ Yes ☐ No Please List: ____________

Are you currently under the care of a physician, physical therapist, or psychologist? ☐ Yes ☐ No If so, Why? ____________

✓ **Please check all conditions that apply & Mark areas you would like addressed on the diagrams:** **Please Mark Below:**

☐ Acne	☐ AIDS/HIV	☐ Anemia	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Athlete's foot	☐ Back Pain
☐ Blood Clots	☐ Broken Bones	☐ Burns	☐ Cancer/Tumors
☐ Bronchitis	☐ Circulatory Problems	☐ Constipation	☐ Cuts or Sores
☐ Diabetes	☐ Diarrhea	☐ Dizziness	☐ Epilepsy
☐ Fatigue	☐ Fractures	☐ Headaches	☐ Hernia
☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol	☐ Insomnia
☐ Joint Disease	☐ Kidney Disease	☐ Liver Disorder	☐ Lung Disease
☐ Nervousness	☐ Paralyses	☐ Plates / Screws	☐ Pregnant
☐ Rash	☐ Sinusitis	☐ Skin Problems	☐ Spinal Problems



How did you hear about our Massage Therapists? ____________

I understand that a massage therapist provides the massage/bodywork I receive for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes will be adjusted to my level of comfort. I further understand that massage and bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. Lastly, I authorize instructor observation and demonstration of techniques if so warranted.

Client Signature____________________ Date ____________

Consent to Treatment of Minor: My signature below hereby authorizes an West End Chiropractic Certified Massage Therapist to administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian____________________ Date ____________

OFFICE POLICY

The following is a summary of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have regarding your account.

Massage Policies:

- **Cancellation Policy**: If you cannot make your appointment we ask that you please contact our office 24 hours in advance to cancel. If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'
- **No Show Policy**: If you fail to cancel your appointment according to the cancelation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. If you fail to show up for your appointment time or fail to cancel according to the 'Cancellation Policy' you will surrender your payment for this appointment. The 'No Show' fee is $39 for every occurrence.
- **Refusal of Service Policy**: We reserve the right to refuse to provide services to any person at anytime. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

Gift Card Policies:

- **Gift Cards**: Our clinic sells massage certificates and can be purchased at any time, year round.
- Gift cards are non-refundable, and are not redeemable for cash.
- Gift card rates are subject to price increases. If the price does increase, you will be responsible for the upgrade charge.

By signing below I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined above.

Patient Name (Please Print):____

Patient / Guardian Signature:_______________________________________ **Date:** ___________________

SUMMARY OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR PHI RELEASE

Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operations including routine aspects of operating a health related practice or business.

Acknowledgement and Consent:

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the creation, uses and disclosures of my PHI. I understand that West End Chiropractic has the right to change its Notice of Privacy Practices from time to time an that I may contact the Privacy Officer for West End Chiropractic at or through the address listed below to obtain a current copy of the Notice of Privacy Practices.

I also understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I further agree that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Privacy Officer Contact Information:

The privacy officer for West End Chiropractic may be contacted by mail by writing: Attn: 1660 Hwy 100 S, Ste 146 St. Louis Park, Mn 55416.

Office Use Only:

The following is practice documentation of our good faith effort to obtain acknowledgement of the above. Patient's acknowledgement of this notice could not be obtained due to the following situation:

- ☐ Patient Refused to Sign.
- ☐ Communication Barrier Prohibited Obtaining Acknowledgement.
- ☐ Emergency Circumstances
- ☐ Other:______________________________________

Signature of Practice:______________________________________ Date: _______________________

Patient Name (Please Print):______________________________________

Patient / Guardian Signature:______________________________________ **Date:** ____________________