West Chester Acupuncture and Chiropractic

Dr. Julie Hilbert, DC, FIAMA, DiplAc. – Dr. Burton Young, DC, FIAMA, DiplAc.
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

Are you pregnant? ( )Yes ( ) No If Yes....How many weeks______________

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?

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

2023 Insurance Update

Patient Information

Patient Name: ______________________________

Address: ______________________________ Zip: __________

Phone Number: ____________________ Patient DOB: __________

Email: ______________________________

****PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD TO COPY WHETHER IT IS NEW OR THE SAME****

Insurance Information Is this a new insurance plan for 2023? YES NO

****IF YOU HAVE A NEW INSURANCE COMPANY PLEASE FILL OUT THE INFORMATION BELOW****

Insurance Company Name: ______________________________

Primary Cardholder Name: ______________________________

Primary Cardholder DOB: __________ Relation to Patient: __________

Insurance ID #: ____________________ Group#: __________

Primary Cardholder Employer: ______________________________

Check below how you would like to receive appointment reminders:

☐ **Text message** ☐ **Phone (home/cell)** ☐ **Email**

HIPPA Privacy Act Laws

☐ By subscribing my name below, I acknowledge my understanding and agreement to these terms. I do not want a copy of my HIPPA laws at this time.

☐ By subscribing my name below, I acknowledge receipt of a copy of the above-mentioned notice and my understanding and agreement to its terms. I have requested a copy of my HIPPA laws at this time.

______________________________ __________

Signature of Patient (or Guardian if under 18) Date

WEST CHESTER ACUPUNCTURE AND CHIRIOPRACTIC
DR.JULIE HILBERT AND DR.BURTON YOUNG
7665 Monarch Ct. Suite 110, WEST CHESTER, OHIO 45069
513.777.9428 (FAX) 513.777.3628