Welcome to West Plains Wellness

Please take a few moments to fill out this Health Intake. This will help us to serve you better.

Last Name: _____ First Name: _____

Address: _____ Birthday: _____

City/State: _____ Zip Code: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____

Type of Employment: _____ Hours Per Day/Week: _____

Emergency Contact: _____ Phone #: _____

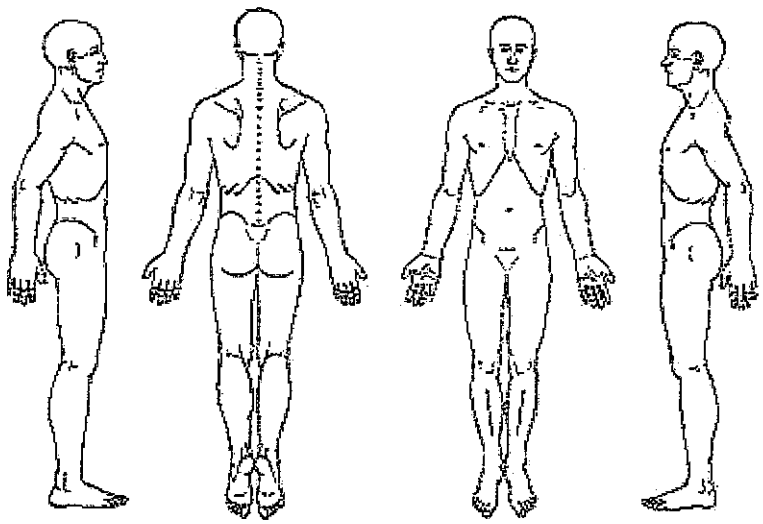
Medical Information: (Circle if any of these symptoms or conditions **currently** apply)

Allergies to oils or lotions	Broken Bones	Arthritis
Scoliosis	Heart Condition	High or Low blood pressure
Impetigo	Contact Lenses	Skin condition (s)
Bursitis	Diabetes	Stroke
Infectious Disease	Cancer	Pregnant (due date_____)
Migraine	Seizure	Varicose Veins
Skin Disorder(s)	Epilepsy	Other: _____

Recent Surgeries: _____ Prescriptions: _____

Primary Physician: _____ Phone #: _____

Please mark on the body where you experience pain:



Circle the type(s) of Pain?

Pinching Aching

Tingling Radiating

Numbness Other: _____

What aggravates this pain?

_____

_____

What relieves this pain?

_____

_____

Have you been in a motor vehicle or work accident in the past year?

YES/ NO

What other things have you tried to resolve your condition?

Physical Therapy	Personal Training	Chiropractic	Medical Doctor
Acupuncture	Cold Laser	Infrared Sauna	Massage

Other: _____

Missed Appointment Policy

With the exception of emergencies, it is vital that you keep all your appointments. Appointment printouts or text/email reminders are provided to help you save the date. If you need to reschedule an appointment, please call our office and arrange for a make-up appointment. In the instance of last minute/rescheduled appointment or a **NO SHOW** without notice by phone or email(**within 24 hours**), we reserve the right to charge you a **$25 Fee**.

Notice of Privacy Policies

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Washington. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and systems are secure from unauthorized access and our staff is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activities, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text/email messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept. of Health and Human Services. We thank you for being a patient at our office.

I have read and fully understand the above statements. All questions pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Massage Therapy care on this basis.

Date _____

Printed Name _____

Signature _____

Office Use Only: Therapist Intake Form

Have you had Massage Therapy before?

What do you spend most of your time doing?

What is happening with your Body that prompted you to seek Massage Therapy?

Explain your pain to me:

What other modalities have you sought for relief?

Explain Expectations and Treatment for the Session

Office Use

Policy Notifications

We appreciate that you've chosen us for your massage and bodywork needs. To provide the best service possible to our patients, we have implemented the following policy updates. Please initial next to each policy.

_____ Inappropriate Behavior Policy

Massage Therapy is for relaxation and therapeutic purposes only. There is absolutely no sexual component to massage whatsoever. Proper draping techniques will also be followed, please do NOT ask us to alter our draping policy. **Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future.** You will be charged the full session fee regardless of the length of your session. Depending on the behavior exhibited we may also file a report with the local authorities, if necessary. Treat your therapist with respect and dignity and you will be treated the same in return. All patients will need to wear undergarments (boxers, briefs, underwear; bras optional) during the massage session. If you don't have any on, you may leave your bottoms on or shorts will be provided to you.

_____ Reschedule -- Cancellation Policy

We respectfully ask that you provide us with a 24-hr notice of any schedule changes or cancellation requests. Please understand that when you cancel or miss your appointments without providing a 24-hr notice, we are often unable to fill that appointment time. This is an inconvenience to your therapist and our other patients miss the chance to receive services they need. For this reason, you will be charged a $25 Less than 24-hr Cancellation/ No Show Fee. We also reserve the right to require a credit/ debit card number to be given to book future appointments so that appropriate fees may be charged if a late cancellation does occur. We appreciate your understanding that we may need to reschedule your appointment last minute due to events out of our control. We do our best to schedule your massage with a West Plains Wellness provider of your choice, however, you may not be informed ahead of time if that appointment has been rescheduled to a different provider within West Plains Wellness. We will not schedule you with an Out of Network provider.

We understand that emergencies can arise and illnesses do occur at inopportune times. If you have fever, a known infection, or have experienced vomiting or diarrhea within 24 hours prior to your appointment time, we request that you cancel your session. Inclement weather may also result in the need for late cancellations. We will do our best to give advanced notice if we are closing or need to cancel due to bad weather and we ask that you do the same. Please do not risk your own safety trying to make your appointment. Late cancellation due to emergency, illness, or inclement weather will generally not result in any no show fees, but this is determined on a case-by-case basis.

_____ Late Arrival Policy

We request that you arrive 5-10 minutes prior to your appointment time to allow time to fill out any required paperwork as well as answer any intake questions you or your therapist might have. We understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so we can do our best to accommodate you. Appointment times are reserved for each patient, so oftentimes we cannot exceed that reserved time without making the next patient late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time. Full-service fees will be charged even when sessions are shortened due to late arrival. In return, we will do our best to be on time, and if we are unable to do so, we will add time to your current session or a future session. If we are unable to adjust times, we will adjust the fees associated with your massage session.

By signing below, you agree to abide by these policies.

(Print Name) _____(Date) _____

(Patient Signature) _____

west plains Wellness

WEST PLAINS WELLNESS 12727 W. 14TH AVE AIRWAY HEIGHTS, WA 99001
PH: 5092444818 FAX: 5092448945 EMAIL: westplainswellness@gmail.com

Massage Therapy Informed Consent And Liability Release

Due to the outbreak of the Coronavirus, aka COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as increased sanitation and disinfecting procedures as recommended by the Washington Dept of Health and the CDC. Please complete the following and sign below.

Symptoms of COVID-19 include but are not limited to:
Fever of 100*F or above, Fatigue, Dry Cough, Difficulty Breathing, Respiratory or flu like symptoms, sore throat, or shortness of breath

I, _____ (print name), agree to the following:

- I understand the above symptoms and affirm that I, as well as household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
- If necessary, I agree to having my temperature taken prior to receiving massage therapy.
- I affirm that I, as well as household members, have not been diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a "Hot Spot" for COVID-19 infections within the last 30 days.
- I understand that this business and my massage therapist or other providers in this office cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the misinformation of the health histories provided by other clients.
- I understand the risk that I am taking by being a willing participant to receive a massage in this facility and I accept ALL responsibility in the event that I test positive for COVID-19 at any time following my massage.
- I agree to update my current health status should it change at any time after receiving massage therapy at this facility and that I may be asked to sign a new informed consent and liability release.

I, _____ (print name), am seeking Massage Therapy Services because I believe that my care is Urgent and Medically Necessary to my Health and Well-being. I believe that a delay in treatment could cause one or more of the following: worsening of significant or severe pain, dysfunction in daily life or work, increased loss of function, resulting in a less-positive ultimate medical outcome, resulting in more complex future treatment or deterioration of the following conditions or overall health, or the following condition is at risk of progressing or causing advancement of the disease process. (These guidelines are provided by WA DOH).

****Please mark all options below that apply to you** (choose at least one)****. My reason(s) for seeking care at this time is/are:**

___My current Pain level on a scale of 1-10 (10 being most Severe) __Pain Management for Acute Symptoms:

(Whiplash, Migraines, Lymphatic Drainage, etc) ___Auto Accident ___Work Injury (LNI) ___Mental Health

____Other injury: _____

_____

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this Therapist. **I agree to each of the above statements and release the Massage Therapist, other Providers in this office and this business from any and all liability for the unintentional exposure or harm due to COVID-19 or any other contagion.**

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____