CopperWell Chiropractic & Massage

5069 W 13400 S Ste 100 Herriman UT 84096

First Name: _____ Last Name:_____

Email: _____Cell: (____)_____

Home Address: _____City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Sex: Male Female

How did you Hear about us?_____

TRANSACITONAL EMAILS

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Initial to opt in:_____

INFORMED CONSENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not receive the care.

I understand that the massage given to me is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, and/or offers a positive experience of touch. I understand that this is not to diagnose an illness or disease and I will not receive a prescription for medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. I understand that massage is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have. I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes especially the use of corticosteroids.

Initial:_____I have read and consent to the above

CANCELATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the providers’ day that could have been filled by another patient. As such, we require 36 hours notice for any cancellations or changes to your appointment. Patients who provide less than 36 hours notice, or miss their appointment, will be charged a cancellation fee that must be paid prior to rescheduling. The cancelation pricing is always posted in the office and can be up to the full price of booked services.

Initial:_____ I have read and agree to cancelation policy

List ALL medications you are taking and what it is prescribed for:

List all supplements you are currently take and for what conditions:

Please list all known allergies:

List all health conditions you have been treated for over the last year and the location or doctor who treated you:

Check all that apply to your personal medical history and explain in the space provided:

- [ ] Broken Bones
- [ ] Been hospitalized
- [ ] Been struck unconscious/fainting/dizziness
- [ ] Had Surgery
- [ ] Fainted/Passed Out

Please explain your reason for seeking treatment and when symptoms begun: *– Required*

Signature:_____ Date: _____