FOX CHIROPRACTIC
WELLNESS CENTER

Wellness Intake Form

Name: _____ Marital Status: _____ DOB: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact phone: _____ Email address: _____

Emergency contact name: _____ Emergency contract number: _____

How many children do you have? _____ Number of people in household: _____ Who cooks? _____

Occupation: _____ Insurance: _____ ID Number: _____
Do you have an HSA (health savings account)? YES / NO

How did you hear about us? ____ Word of mouth ____Facebook ____ Instagram ____ Search engine

What services are you all interested in? □ Cyotherapy □ Acupuncture □ Chiropractic □ Massage

Do you consider your health to be (circle one**): Excellent Good Poor**

Please list any medications or supplements you are currently taking

_____
_____
_____
_____
_____

Chronic medical conditions or surgeries

_____
_____
_____

Do you have any of these symptoms?

□ Depression	□ Anxiety	□ PMS
□ Acne	□ Dry skin	□ Rash
□ Fatigue	□ Joint pain	□ Muscle pain
□ Acid reflux	□ Intestinal gas	□ Belching
□ Headaches	□ Diarrhea	□ Constipation
□ Bloating	□ Hair loss	□ Food sensitivity
□ Other:		

How long has it been since you have felt well? _____

LIFESTYLE & HABITS

Do you like to exercise? **Y N** Do you exercise regularly? **Y N**

What do you do? _____ How often? _____ How long? _____

Do you drink alcohol? **Y N** If yes, how much? _____

Do you use tobacco products? **Y N**

Do you use marijuana products? **Y N**

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FOOD

How much water do you drink in a 24-hour period? _____ oz

List other fluids you drink in a 24-hour period: _____

How often do you eat in a restaurant each week? _____ How many times a day do you eat meals? _____

Sleep & Stress: How many hrs. of sleep do you get on average? _____ **Do you get stressed often? Y N**

WELLNESS QUESTIONAIRE

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or Frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory/mood swings	0	1	2	3
Use on NSAIDS (Aspirin,Tylenol,Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight trouble	0	1	2	3

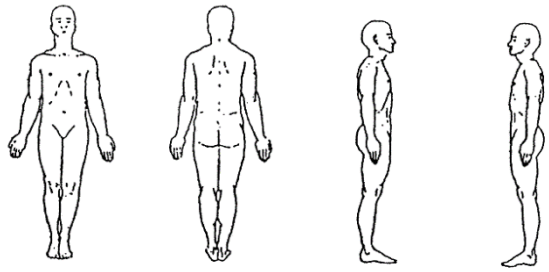
TOTAL (FILLED BY OFFICE)
_____

GOALS

List 3 ways that your life would be better if you weighed less:
_____

_____

_____



Mark on the area most concerning

Rate your current commitment to change: (circle one) **Lowest 1---2---3---4---5---6---7---8---9---10 Highest**

Is there anything else we should know that will help us design a successful weight loss program for you?

_____

_____

Are there any barriers that would prevent you from starting a program?

_____

_____

Please check any of the following services you would like more information about:

□ Chiropractic
□ Decompression Disc Therapy
□ Fascial Contouring
□ Knee Pain Therapy
□ Inflammation Treatment
□ Migraine therapy

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SLEEP & STRESS

How many hrs. of sleep do you get on average? _____

Do you get stressed often? **Y** **N** Rate your average stress level on a scale of 1-10: _____

GOALS

List 3 ways your life would be better if you felt better:

_____
_____
_____

Is there anything else we should know that will help us lead you to better health? Are there any barriers preventing you from making changes?

_____
_____
_____

Rate your current commitment to change: (circle one) **Lowest 1---2---3---4---5---6---7---8---9---10 Highest**

_____	_____	_____	_____
Patient signature	Date	Provider Signature	Date

Localized High Impact Cryotherapy Services

To enable us to ensure your comfort and safety in all the services we provide, please take time to carefully read this form and answer ALL QUESTIONS to your best ability.

All provided information is CONFIDENTIAL and protected – we will never share it with any 3rd parties, unless required by law.

Introduction. What is localized high impact cryotherapy

For localized cryotherapy services, we use one of the newest and most effective technologies on the market - a device by **America Cryo**.

The procedure includes spraying the treatment area with dry vapor of carbon dioxide (CO_2), as cold as -108° F, under pressure as high as 50 bar, in short 30 to 90-second increments. The combination of precise targeting, extremely low temperatures, and strength of the flow results in more rapid and deeper cooling of the affected tissue, producing better results faster.

This technique is not considered a medical treatment, but rapid cooling of the skin and underlying tissue can be used for pain management, stimulation of cell regeneration, tightening and brightening of the skin, anti-aging facials, and reduction of stubborn fat deposits and cellulite, amongst other effects.

Thermal shock improves blood flow in the treatment area and helps reduce inflammation. If applied to fat cells that are more sensitive to cold than any other cell in the body, cooling triggers a process called cryolipolysis and results in apoptosis – controlled permanent destruction of subcutaneous fat tissue.

Localized cryotherapy is safe for most people, but some contraindications have been identified and negative side effects are possible. Familiarizing yourself with the information below to help you avoid unwanted consequences.

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Part I. Tell us about your goals and history of health conditions

What is the main goal that you would like us to help you achieve?

____ Post-injury or post-surgery RECOVERY

____ Athletic RECOVERY

____ PAIN relief

____ Firming, toning, tightening of the SKIN in select parts of the body

____ Lessening of FAT deposits

____ CELLULITE reduction

____ Anti-AGING

____ DOUBLE CHIN reduction

____ Management of a SKIN CONDITION

____ Other. Please, specify: _____

Are you pregnant?	____(Y)	_____(N)
Do you have any cold-induced condition, such as cold hemolysis, cryoglobulinemia, cold agglutination, cold allergies, or other?	____(Y)	_____(N)
Are you hyper- or hyposensitive to cold?	____(Y)	_____(N)
Do you have a trophic disorder?	____(Y)	_____(N)
Do you have any sensory processing disorder?	____(Y)	_____(N)
Do you suffer from polyneuropathy?	____(Y)	_____(N)
Do you have a deficient kidney or liver function?	____(Y)	_____(N)
Do you have an impaired lymphatic system?	____(Y)	_____(N)
Do you have vasculitis (inflamed blood vessel walls)?	____(Y)	_____(N)
Do you have diabetes-related microvascular issues?	____(Y)	_____(N)
Do you have impaired arterial blood flow?	____(Y)	_____(N)
Do you have chronic venous insufficiency?	____(Y)	_____(N)
Do you have a blood disorder related to coagulation?	____(Y)	_____(N)
Do you have cancer or undiagnosed lumps?	____(Y)	_____(N)
In or around the intended treatment area:		
Have you had Botox or fillers in the last 2 weeks?	____(Y)	_____(N)
Have you had any recent skin-sensitizing treatments?	____(Y)	_____(N)

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Do you have any open wounds or lesions? ____(Y) _____(N)

Is your skin sunburn or frostbitten? ____(Y) _____(N)

Please note that this list is indicative but **not exhaustive** - if you have any injury, illness, a serious medical condition, or a health-related concern, we strongly suggest consulting a physician prior to using localized high impact cryotherapy.

Part II. Advisements and contraindications

Having any of the contraindications described in this document will require you to use discretion for your own well-being.

Cold applications can feel slightly uncomfortable and leave the skin pink for a short period following the session while the skin temperature is returning to normal, but there is no damage, and no recovery required. In case of experiencing any burning sensation, pain, or significant discomfort at any time during our treatments, we strongly advise you to terminate the session immediately upon your own volition.

Localized high impact cryotherapy for pain management

We use a high-pressure flow of gasiform CO_2 to lower the tissue temperature in the treated area. This process, called cryostimulation, causes constriction of the blood vessels in response to cold, followed by dilation and improved blood flow post-treatment, reducing inflammation and swelling and stimulating release of hormones like noradrenaline and Beta-Endorphins which are powerful natural pain killers.

Applications include athletic recovery, recovery from soft tissue, muscle, tendon, or overuse injuries or surgery, and painful motion-limiting medical conditions.

This treatment does not impose health risks but **should NOT be applied** to highly sensitive skin or open wounds and should be avoided in case of cold allergies or any other cold-induced condition.

Localized high impact cryotherapy for fat freezing/ body sculpting

In this process, we use a phenomenon called cryolipolysis. Cooling the problem areas to the point when subcutaneous fat cells that are very sensitive to low temperatures get damaged and die leads to gradual slimming. Post-treatment, the body uses the lymphatic system to permanently expel the damaged cells.

Because of the strain that the need to eliminate the cellular debris puts on the body, you **should NOT do** fat freezing treatments if you are pregnant, undergoing dialysis, having only one kidney or any type of kidney or liver disease, or impaired circulatory system. Being oversensitive or allergic to cold, having active cancer, or going through chemotherapy are also contraindicated.

High impact cryo facials

Cold applied to the face, neck, or decolletage causes blood vessels to constrict, then dilate, improving circulation and making the skin look firmer and better toned. The process also soothes inflammation, helps fight bacterial infections like acne and stimulates collagen production that has anti-aging effect.

You **should NOT use** cold if you are cold-intolerant or your skin is highly sensitized by sun or treatments like chemical peels. You should take a 2-week break after procedures like Botox or fillers.

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Part III. Liability waiver

In consideration of using the localized cryotherapy services offered by **Fox Chiropractic Wellness** and by filling out and signing this Intake Form prior to or during your first visit, you have acknowledged the following:

You have been truthful in disclosing your current health condition, as well as past health-related events, including but not limited the ones listed as definite contraindications.

You understand that the services provided by **Fox Chiropractic Wellness**, although they may have certain health benefits, have been designed to enhance health, appearance and vitality in generally healthy individuals. You have been advised that all services have contraindications and that you should ONLY use any treatments if you either don't have the related risks or have discussed these risks with your doctor and obtained their written consent.

You recognize the importance of informing **Fox Chiropractic Wellness** personnel about any changes in your health condition, including pregnancy, as they may compromise effectiveness and/or safety of the services you will be receiving.

You are aware of the need to postpone your appointments with **Fox Chiropractic Wellness** if you are feeling sick and have symptoms like fever, congestion, cough, shortness of breath, chest pain, dizziness, nausea, rash, or if you get an acute infection of any kind. The **Fox Chiropractic Wellness** cancellation requirements and package expiration dates still apply.

You have been informed that results, especially when it comes to fat loss, cellulite, or aging, are not always immediate, and some benefits will continue to develop over weeks, or even months, post-treatment. Because your body and lifestyle are unique, so will be your progress. In some cases, treatment may not be successful, especially if you fail to follow treatment number and frequency recommendations given to you by **Fox Chiropractic Wellness** staff. Commitment to minimum 5 sessions followed by a proper maintenance protocol is paramount for success.

You consent to commit to promptly following all safety and other behavior- and treatment-related instructions posted through the studio or given to you by **Fox Chiropractic Wellness** personnel.

You accept the responsibility to immediately inform **Fox Chiropractic Wellness** if you feel discomfort or experience any adverse effects from any treatment that you are undergoing, as they may indicate the need to discontinue the service.

You confirm that you have been explained and understand the administration of the localized high impact cryotherapy services provided by **Fox Chiropractic Wellness**, including possible adverse reactions, side effects, or complications. They are rare, but, when extreme cold is involved, minor frostbites may occur and may lead to long-term sensitivity of the affected area to heat or cold post-event.

Based on the above, YOU VOLUNTARILY ASSUME FULL RESPONSIBILITY for engaging in the said services and AGREE TO INDEMNIFY AND HOLD **Fox Chiropractic Wellness** HARMLESS from any consequences and related costs that may incur due to your use of any of the treatments.

You also acknowledge that you have been given no warranty or guarantee of any particular results. You understand that the outcome depends not only on the treatments, but also diet, lifestyle choices and numerous other factors outside **Fox Chiropractic Wellness**' control.

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Part IV. Consent to use clinical photographs

Except for pain management, clinical photographs play a key role in monitoring your progress over the weeks of treatment and education of our staff. They also help inform equipment suppliers in the process of continuous development of new applications and better technologies.

Different types of consent are required according to the way in which clinical images will be used. Please CHOOSE ONE of the below. If you do not fully understand what each option implies, please ask. Please note that we must take photographs to monitor your progress; so, at least the lowest level of consent (case notes) is REQUIRED.

Your choice of consent level will not affect your treatment in any way.

_____ CONSENT TO OPEN PUBLICATION. I give my consent to ANONIMOUS publication of my progress images in a journal, textbook, marketing materials or open access websites which may be seen by wellness professionals outside **Fox Chiropractic Wellness**, as well as members of general public. Anonymity means focusing only on the treated body part and not showing my full face or disclosing my name.

_____ CONSENT TO RESTRICTED EDUCATIONAL USE. I agree with ANONIMOUS use of my progress images only by professionals for the purposes of cryotherapy research and education of people seeking to become professionals. Anonymity means focusing only on the treated body part and not showing my full face or disclosing my name.

_____ CONSENT TO CASE NOTES ONLY. I understand that the illustrations requested here, to which I have agreed, will only form part of my confidential treatment records and will be used by nobody, but the **Bremerton Wellness** staff directly involved in providing the services of my choice.

Authorization, waiver, and consent

I am: _____ the client _____ a parent/legal guardian of the client under 18

I hereby confirm that all information provided by me herein is correct to the best of my knowledge, and I have disclosed all health-related risk factors that I know of. I understand that treatment safety may depend on my health status.

By signing this document, I CONFIRM THAT I HAVE READ, UNDERSTOOD AND AGREED with the treatment-related risks, liability waiver, and provisions of the **Fox Chiropractic Wellness** Service Terms and Conditions.

By signing this document, I ALSO CONFIRM THAT I HAVE BEEN EXPLAINED AND AGREE with the choice of consent level related to the use of the “before” and “after” photographs.

I am aware that, to withdraw my earlier given consent that I could do any time without any impact on the services I will be receiving, I must request it in writing.

_____ _____

Patient signature Date