Mountain Chiropractic

Confidential Client Health History Form

Name: _____ Birthdate (m/d/y): _____

Address: _____ Postal Code: _____

Phone: _____ Cell: _____ Email: _____

Occupation: _____ Emergency Contact: _____

Physician Name & Number: _____

Other health care practitioners (Chiro, Physio, Naturopath, Acupuncture, etc) :

_____

How did you hear about us: _____

Have you had therapeutic massage before? Yes / No **If yes- when was last treatment date?** _____

What was your experience? _____

Primary reason for appointment? (relaxation, stress, pain relief, MVA, etc) _____

Ladies: Are you or could you be pregnant? Yes / No **If so, # of weeks:** _____

Hobbies / Sports: _____

Describe your sleep patterns: _____

Do you have difficulty lying in a certain position? _____

List any serious or lasting trauma: _____

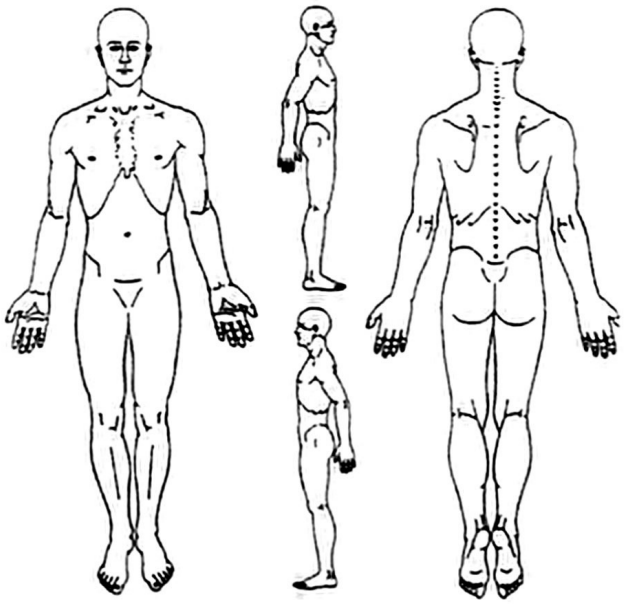
_____

List any surgeries in the last 5 years: _____

PLEASE CHECK (✓) IF YOU HAVE A HISTORY OF/OR BEEN DIAGNOSED FOR:

Arthritis	❒	Hepatitis	❒
Allergies/skin sensitivities	❒	HIV/AIDS	❒
Asthma	❒	Heart Problems	❒
Blood clots	❒	Varicose veins	❒
Cancer (Type: _____)	❒	High/low Blood pressure	❒
Circulatory problems	❒	Hernias	❒
Digestive problems	❒	Hemophilia	❒
Diabetes	❒	Osteoporosis	❒
Excessive Swelling	❒	Respiratory Illness	❒
Fluid Retention	❒	Seizures	❒
Frequent Headaches	❒	Scoliosis	❒
Joint/ muscle pain	❒	MS/ALS/Parkinsons	❒
Other:	❒	TMJ/Jaw Pain	❒

PLEASE CIRCLE AREAS OF CONCERN:



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Are you currently in pain? Yes / No

Please check (✔) areas in which you are currently experiencing (pain/soreness/difficulty)

Head	❒	Hands	❒	Quadriceps	❒	Ankles/ feet	❒	Neck	❒		
Pectorals	❒	Hamstrings	❒	Upper back	❒	Arms	❒	Stomach	❒		
Knees	❒	Mid back	❒	Shoulders	❒	Gluteals	❒	Calves	❒		
Low back	❒										

Do you live with pain on a daily basis? Yes / No

If yes, please rate **daily** pain on a scale of 1 (very mild) to 10 (extreme) : 1 2 3 4 5 6 7 8 9 10

If no, please rate your **current** pain on a scale of 1 (very mild) to 10 (extreme) : 1 2 3 4 5 6 7 8 9 10

Do you have any allergies: _____

_____

Do you have any other health or unusual symptoms? _____

_____

Are you taking any medications (including over the counter), vitamins, herbs, homeopathics? For example:

Aspirin ❒ Ventilators ❒ Insulin ❒ Anti-depressants ❒ Muscle relaxers ❒ Vitamins ❒

Anti-inflammatories ❒ Pain Killers ❒ Herbs: _____

Other: _____

Do you experience high levels of stress in your day to day life? Yes / No

Please check all areas causing stress: Work ❒ Family ❒ Injury/ill health ❒ Other: _____

ALL INFORMATION COLLECTED ON THIS FORM IS STRICTLY CONFIDENTIAL AS WELL AS ANY CONVERSATION THAT TAKES PLACE IN THE CLINIC ROOM.

I _____ STATE THAT THE ABOVE INFORMATION IS CURRENT AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AM AWARE THAT THE MASSAGE THERAPIST IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS AND/OR DIAGNOSIS AND IT IS RECOMMENDED THAT I SEE A PHYSICIAN FOR ANY PHYSICAL/ EMOTIONAL AILMENT THAT I MAY HAVE. I RELEASE MY MASSAGE THERAPIST OF ANY AND ALL LIABILITY IF I DO NOT TAKE IT UPON MYSELF TO KEEP THE MASSAGE THERAPIST REGULARLY UPDATED ON MY PHYSICAL HEALTH.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN IF UNDER 18: _____

Consent for Therapy and Waiver of Liability

Client agrees as follows:
Client understands and agrees that they will provide the Therapist with complete and accurate health information. A written referral from Client's primary healthcare provider is required if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1) Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manual therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and received all requested information.

2) Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to the Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behaviour on the Client's part, will result in immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.

3) Client hereby assumes full responsibility for receipt of the massage therapy, an releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist to the fullest extent allowed by law.

4) Client, in signing this consent for Therapy and Waiver Liability, understands and agrees that this Consent will apply to and govern the current and future therapy sessions performed by the Therapist.

Client (Print Name)	Client (Signature)	Date

Therapist (Print Name)	Therapist (Signature)	Date

CANCELLATION AND COLLECTION OF CREDIT CARD INFORMATION POLICY

We ask you adhere to our cancellation policy as our Therapist's time, and your time, is valuable:

- You may cancel your appointment without charge any time before the close of business on the business day preceding your appointment.
- Same day cancellations will be charged 50% of the scheduled service.
- If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

Same day appointments:

Please be aware that when booking an appointment on the same day, it is considered set, and if changed, cancelled or rescheduled at any point after it is made, the client is responsible for paying for the full price of the appointment.

If you have an emergency, please let us know so that we can treat your specific situation with personal attention.

We do not consider scheduling conflicts to be emergencies.

Please call the clinic at 403-845-3536 to cancel an appointment.

E-mail cancellations will not be accepted.

As a client, you agree to provide credit card information to be stored in the secure website connection in the event of late cancellations.

Your credit card will never be charged without prior notification.

_____	_____	_____
Name (Print)	Signature	Date

_____	_____ / _____	VISA/MC
Card Number	Expiry (MM/YY)	(Please Circle)