ENERGY Chiropractic

New Massage Client - Health History

Name: _____ Date: _____

Address: _____ Postal Code: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Contact Person (in case of emergency):_____ Phone: _____

Relationship to You:_____

Date of Birth: _____ Occupation: _____

Physician's Name: _____ Medications using: _____

May we contact you by email? **(appointment reminders & payment receipts only)** □ Yes □ No
Email address: _____

List physical activities you do on a regular basis: _____

_____

How did you find out about our clinic? _____

If recommended, please state name: _____

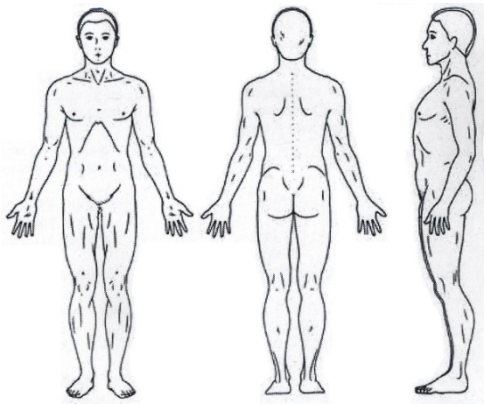
Please circle the appropriate answer to the following:

Do you faint easily?	Yes	No
Do you wear contact lenses or dentures?	Yes	No
Do you have a history of allergic reactions or asthma?	Yes	No
Do you have any spinal problems?	Yes	No
Are you pregnant?	Yes	No
Have you been diagnosed as HIV Positive	Yes	No
Have you had massage before?	Yes	No

Other Symptoms:
Please mark any of the following conditions or symptoms that you have now or have experienced:

- □ Headaches
- □ Neck pain
- □ Whiplash Injury
- □ Bone spurs
- □ Low back pain
- □ Nervousness
- □ Tension
- □ Irritability
- □ Dizziness
- □ Neck Stiff
- □ Joint swelling
- □ Fever
- □ Loss of balance
- □ Ringing in ears
- □ Jaw/TMJ problem
- □ Pain in hands or arms
- □ Numbness in hands or arms
- □ Loss of consciousness
- □ Pain in legs or feet
- □ Numbness in legs or feet
- □ Fatigue
- □ Depression
- □ Lights bother eyes
- □ Shoulder pain
- □ Sinus
- □ Shortness of breath
- □ Asthma
- □ Allergies
- □ Cold hands
- □ Cold feet
- □ Chest pains
- □ Heart attack
- □ Sudden collapse (still conscious)
- □ High blood pressure
- □ Stroke
- □ Cancer
- □ Painful urination
- □ Diabetes
- □ Constipation
- □ Stomach upset
- □ Heartburn/reflux
- □ Weight loss
- □ Loss of smell or taste
- □ Menstrual cramps
- □ Menopause

Shade painful areas of injury, pain or discomfort on the figures below:
Rate painful areas, 1 – 5, where 5 is the most painful.



Date of injury and/or onset of pain: _____

What causes it? _____

What relieves it? _____

Other therapies or treatments you are receiving or received for this condition:

_____

Do you have any other medical condition of which the therapist should be aware? If so, please specify:

_____

Authorization for Care

I,_____, understand massage therapy given at Energy Chiropractic is for the purpose of soft tissue injury relief.

I understand that the massage therapist does not diagnose illness, disease or other physical or mental disorders. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any chiropractic manipulations.

It has been made clear to me that this massage therapy is not a substitute for medical or dental examinations and/or diagnosis, and that it is recommended that I see a physician for any physical ailment that I may have.

Because a massage therapist must be aware of the client's pre-existing conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Patient Signature: _____

Parent/Guardian Signature (if applicable): _____

Date: _____

Cancellation Policy

Cancelling or rescheduling appointments must be done 24 hours in advance. We reserve the right to charge for missed appointments.