



# *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 only)  Yes  No  
email address \_\_\_\_\_

List physical activities you do on a regular basis:

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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

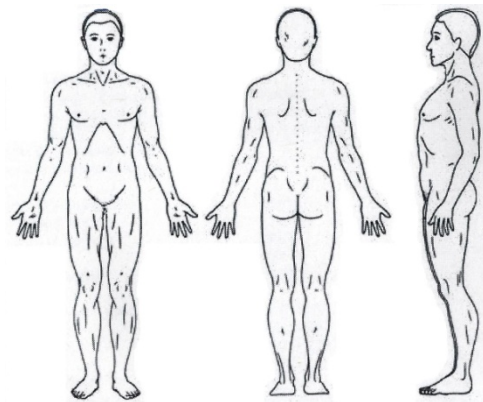
Have you had massage before? Yes No

### **Other Symptoms:**

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

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

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