CHAMPION CHIROPRACTIC
AND SPORTS INJURY CLINIC

Health History & Entrance Form

Last Name: _____ First Name: _____ Date of Birth (YY-MM-DD): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Primary Phone: ☐ Home ☐ Cell _____ Secondary Phone: ☐ Home ☐ Cell _____

Email *(Appointment Reminders Only)*: _____

Occupation: _____ Referred by: _____

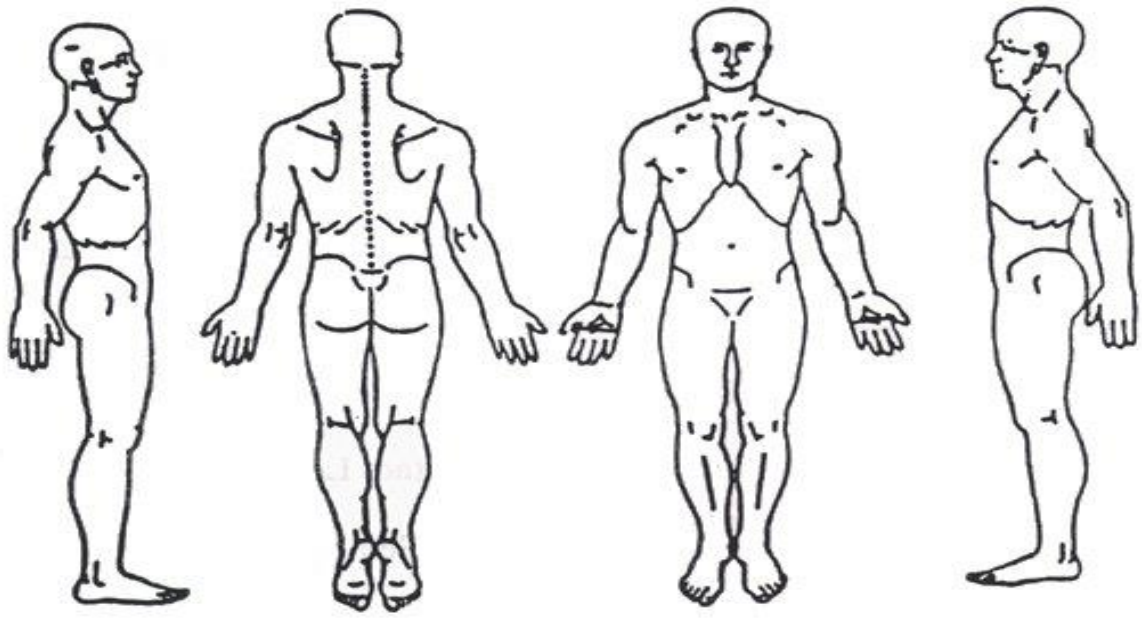
Emergency Contact Name: _____ Relation: _____ Number: _____

Have you experienced a professional massage before? YES / NO Date of last therapeutic massage: _____

Please indicate one or more of the following reasons for your massage:

☐ RELAXATION.
☐ STRESS RELIEF.
☐ I receive REGULAR MASSAGES and am here for general muscle health/preventative care.
☐ I have LIFE STYLE-RELATED tension that I need relief from.
☐ I have a SPECIFIC INJURY or have been in a MOTOR VEHICLE ACCIDENT that I would like to recover from.

Please CIRCLE the areas of *tension/achiness*, X the points of *sharp/stabbing pain*, SHADE areas of *numbness/tingling* and label each one on a scale of 1-10 (10 being the most intense pain you have felt).



The pain interferes with: ☐ Work ☐ Sleep ☐ Sports ☐ Daily Routine
What relieves the pain? _____
What makes the pain worse? _____
Are you presently using any other therapies for the pain? ☐ Chiro ☐ Acupuncture ☐ Physiotherapy ☐ Other: _____

Please CIRCLE the conditions that are *presently* causing you problems and CHECK the conditions that have been a problem to you in the *past*.

Muscles & Joints
- ☐ Arthritis
- ☐ Plantar Fasciitis
- ☐ Bursitis
- ☐ Shin Splints
- ☐ Swelling of Joints
- ☐ Dislocations
- ☐ Tennis / Golfers Elbow
- ☐ Carpal Tunnel
- ☐ Scoliosis
- ☐ Pins / Artificial Joints
- ☐ TMJ
- ☐ Whiplash
- ☐ Fibromyalgia

Skin
- ☐ Chronic Rashes
- ☐ Warts
- ☐ Body Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot

Cardiovascular
- ☐ High Blood Pressure
- ☐ Aneurysm / Stroke
- ☐ Varicose Veins
- ☐ Bruise Easily
- ☐ Poor Circulation
- ☐ Heart Disease / Heart Attack
- ☐ Stint / Pacemaker

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Chronic Sinus Problem

Women:

Are you Pregnant? YES / NO

Due Date:

_____

General Symptoms
- ☐ Depression
- ☐ Anxiety / Stress
- ☐ Headache
- ☐ Migraines
- ☐ Vertigo
- ☐ Fainting / Dizziness
- ☐ Blackout
- ☐ Deafness / Hearing Aids
- ☐ Osteoporosis
- ☐ Kidney Infections
- ☐ Cancer
- ☐ Diabetes: Type _____

Lifestyle (Circle all that apply)

Regular Exercise	YES	NO	MOSTLY
Drink Plenty of Water	YES	NO	MOSTLY
Healthy Eating	YES	NO	MOSTLY
8 Hours of Sleep	YES	NO	MOSTLY

Other Conditions: _____

_____

_____

Do you have a family history of any of these conditions? YES / NO If yes, please list: _____

_____

Current Medications: _____

Major Injuries / Surgeries: _____

Allergies: _____

I have read, understand, and agree to the following:

- The information I have provided is true and complete to the best of my knowledge. I am responsible to inform the therapist of any changes to my medical conditions. There shall be no liability on the massage therapists part should I fail to do so.
- If receiving cupping as part of my treatment, I understand that cupping is performed by the suction of skin at certain points of the body. I am aware that this could result in local bruising, pain, or discomfort and possible aggravation of symptoms existing prior to treatment. Cupping does commonly leave marks on the skin that vary in pattern and color (from light red to dark purple) usually lasting 3 days to a week and sometimes longer
- The therapist is not a physician and does not diagnose illness, disease, or any other conditions. No assurance or guarantee has been provided to me as to the results of the treatment. The massage therapist reserves the right to refuse to perform massage on anyone whom she considers to have a condition for which massage is contraindicated
- I consent to health assessment/reassessment at therapist's discretion. I understand that all sessions include a pre-health assessment and may change duration of massage time.
- The massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- The therapist can end treatment at any time due to inappropriate comments or behaviour. The full amount of the massage will be charged to my account.
- The personal information that is gathered by Champion Chiropractic employees is shared with other practitioners on site and will otherwise remain confidential unless patient consents to disclosure.

CLIENT SIGNATURE: _____ DATE: _____
(*OR PARENT/LEGAL GUARDIAN)*

WITNESS SIGNATURE: _____ DATE: _____