Bow Valley Chiropractic
Massage intake

email: admin@bowvalleychiro.com
Ph: 403.262.2211

Date: _____/____/_____
MM DD YYYY

Name:_____

Phone: Home: (_____)_____-_____ Work: (_____)_____-_____ Mobile: (_____)_____-_____

Address:_____ City:_____ Postal Code:_____

Birthdate: _____/____/_____ E-mail Address:_____
MM DD YYYY

Occupation:_____ How did you hear about us:_____ Medical Doctor:_____

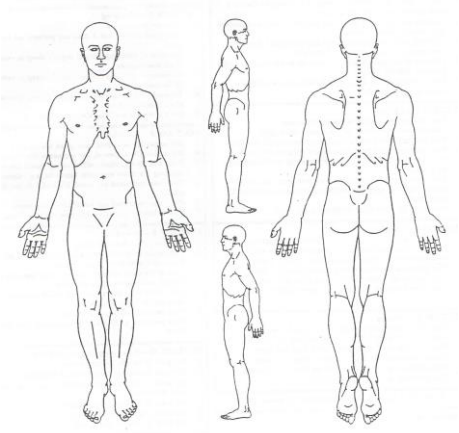
Are you taking any medications: Y/N If Yes, What?_____

List regular physical activities:_____

Please check any of the following conditions you are experiencing:

☐ Arthritis	☐ Heart Trouble	☐ Pregnancy	☐ Back Pain
☐ Sprains/Strains	☐ Bursitis	☐ Jaw Pain	☐ Sciatica
☐ Blood Pressure	☐ Cancer	☐ Joint Dysfunction	☐ Stress
☐ Cold or Flu	☐ Migraines	☐ Tendonitis	☐ Diabetes
☐ Muscle Tension	☐ Tingling / Numbness	☐ Fibromyalgia	☐ Muscle Pain
☐ Varicose Veins	☐ Headaches	☐ Neck Pain	☐ Whiplash

Rate areas or injury, pain or discomfort from 1 to 5 (5 is the most painful). Mark areas below.



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:_____

Authorization for Care: I hereby authorize this clinic and it's doctor(s) and/or massage therapist(s) to administer care, as they so deem necessary to myself, (if applicable to my son/daughter/ward).

Cancellation Policy: If you are unable to provide us with **24 hours** notice on cancelled appointments, there will be a charge for the full price of the appointment.

Signature:_____ Date:_____