Bow Valley Chiropractic

Chiropractic | Massage | Orthotics | Acupuncture

Name: _____ Date: _____/_____/_____
MM DD YYYY

Ph: (_____) _____-_____ E-mail: _____
(optional, used for apt. reminders and direct access to Online Booking system)

Address: _____ City: _____

Postal code: _____ Occupation: _____ Gender: _____

Birthdate: _____/_____/_____ Medical Doctor: _____
MM DD YYYY

Emergency contact: _____ PH:(_____) _____-_____

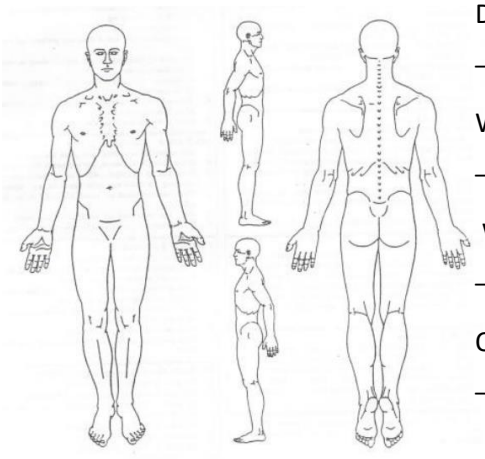
Any medications/surgeries: Y/N If YES, what? _____

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 its 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: _____