Confidential Client Intake Form and Release of Liability

Name:_____ E-mail:_____

Address:_____ Home phone:_____

City, State, Zip:_____ Cell phone:_____

DOB:_____ Work phone:_____

Occupation:_____ Referred by:_____

Emergency contact:_____ Phone:_____

Physicians name:_____ Phone:_____

General Health Information

Have you had professional bodywork before? If yes, how often do you receive bodywork?_____

Do you have any allergies or sensitivities to oils, lotions, scents, etc?_____

What are your exercise habits?_____

How much water do you drink daily?_____

Are you under the supervision of a physician for any health concerns?_____

_____

Any current medications?_____

_____

Any surgical history?_____

_____

Please mark an (X) for current conditions and a (P) for past conditions

__ Abdominal/Digestive problems	__ Chronic pain	__ Hernia	__ Rheumatoid Arthritis
__ AIDS/HIV+	__ Circulatory/Heart problems	__ High/Low Blood Pressure	__ Sciatica
__ Headaches	__ Currently pregnant	__ Insomnia	__ Severe Tension/Stress
__ Anxiety	__ Depression	__ Migraines	__ Spinal disorders
__ Arthritis	__ Diabetes	__ Muscle Spasms/Cramps	__ Sprains/Strains
__ Asthma or lung conditions	__ Disc Problems	__ Muscle injuries	__ Varicose veins
__ Blood clots	__ Fatigue	__ Numbness/tingling	__ Rash/fungus
__ Carpal Tunnel	__ Fibromyalgia	__ Osteoarthritis	__ Tendonitis/Bursitis
__ Cancer	__ Lupus	__ Osteoporosis	__ TMJ (jaw pain)

Other:_____

Reason for today's visit

What would you like to focus on with today's treatment?

_____

_____

_____

How long have you been having this issue?_____

Have you sought medical attention for this issue?_____

Have you tried and/or gotten relief with any other treatments?_____

_____

_____

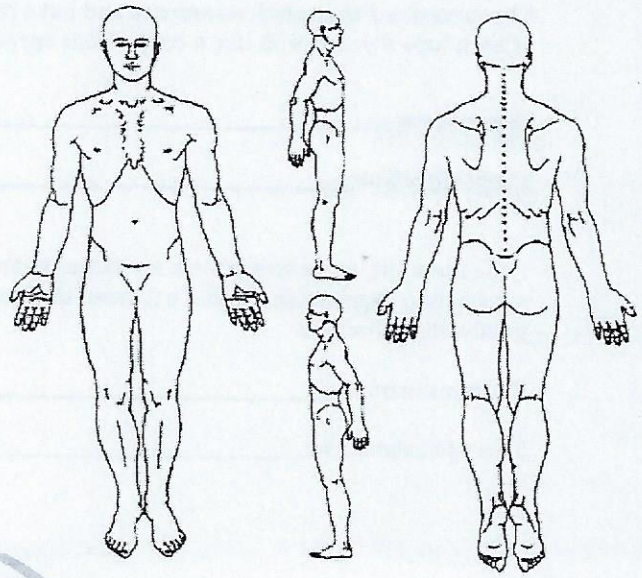
Please rate on a scale from 0 – 10 (10 being very high)

___ Stress ___ Pain ___ Energy

Please circle any areas of pain or tension on the diagram to the right

Please mark with an "X" any areas you would like avoided

(genital and breast areas will always be avoided)



OVER →

Bodywork Client Waiver Form

Please take a moment to read and initial each of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

___

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

___

I affirm that I have notified my therapist of all known medical conditions and injuries. I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

___

I understand that bodywork is entirely therapeutic and non-sexual in nature.

___

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

___

I understand that should I cancel an appointment less than 24 hours before the scheduled time or "no show" an appointment, I am subject to a fee equal to the cost of the missed appointment. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.

___

Information and Suggestions

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear clothing (loose, comfortable clothing will not interfere with your treatment). You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained healthcare professional and wants to make you feel informed and comfortable.

I have received the policy statement, and have read and agree to the policies therein.
(Check here if you would like a copy of this agreement ___)

Client name:_____

Client signature:_____ Date:_____

I, the therapist, agree to perform my duties to the best of my ability keeping client health, safety, well-being and satisfaction foremost in mind. I will keep all client information and details in strict confidence as indicated by law and good ethical practice.

Therapist name:_____

Therapist signature:_____ Date:_____

Dr. Colleen Krahl, DC, CAC
(480) 595-0001
info@championcavecreek.com

I am requesting authorization for the following animal(s)to undergo exam and treatment:

Name: _____ DOB/breed/color: _____

Name: _____ DOB/breed/color: _____

Name: _____ DOB/breed/color: _____

I am of lawful age, do understand, authorize, consent, and can substantiate the following:

1. CREDENTIALS: Champion Chiropractic is comprised of a Doctor of Chiropractic, Dr. Colleen Krahl, licensed in human care. Dr. Krahl has completed postgraduate work in order to become certified by the American Veterinary Chiropractic Association in order to practice animal chiropractic.

2. SCOPE: Champion Chiropractic is NOT a veterinarian and does not intend to replace traditional vet care or take responsibility for my animal's primary healthcare needs. I am seeking chiropractic for my animal(s) as a complementary therapy to be used concurrently with my current veterinary care. The AZ Board of Chiropractic opined on Aug 19, 2015, that animal chiropractic is within the scope of practice in Arizona. Chiropractic does NOT include: dispensing/injecting medication, performing surgery, recommending supplements, or providing any traditional veterinary care.

3. RECORD SHARING: I hereby allow Champion Chiropractic and my referring vet to share any and all records so they can better collaborate on my animal's treatment. I allow Champion Chiropractic to share records with any and all members of my animal care team (I.e: trainers, massage therapists, groomers, etc). I hereby also allow use of my pet's health information for research purposes to advance the field of animal chiropractic.

4. INFORMED CONSENT: Champion Chiropractic has explained their scope of practice and the procedures to be performed. They have explained risks and benefits of treatment to my satisfaction. I understand that there is no guarantee to the nature of my animal's condition or the resulting outcomes of treatment. I understand Champion Chiropractic's intent is to do no harm, but I also understand that negative reactions to treatment can occur (such as, but not limited to: fracture, dislocation, disc injury, strain/sprain, worsening of present condition, stroke, or neurologic impairment.) I will indemnify and hold harmless Champion Chiropractic and my referring veterinarian should any negative reactions occur.

5. LIABILITY: Champion Chiropractic has made me aware that they carry their own malpractice and liability insurance. However, I understand that I am solely responsible for any harm caused by my animal to myself or any other animal, person, or property while under Champion Chiropractic's care. This includes any financial obligation that may result due to my animal's behavior.

6. FEES: Champion Chiropractic has made me aware of their fee schedule. I agree to pay at the time of service for services rendered and for travel costs accrued. I do understand and consent that Champion Chiropractic may save my payment information and can charge cancellation fees if I do not cancel within 24-hour notice of my appointment. I understand that they can deny future services if I have a credit on my account.

7. PET INSURANCE: I understand that Champion Chiropractic is not a contracted provider with any insurance companies. My insurance policy is a relationship between myself and my insurer. Upon each service, I will be provided a receipt that I may use for my own submission to my insurer. In submission, I understand there is no guarantee for reimbursement for services rendered and I do not hold Champion Chiropractic responsible for providing any records or receipts to my insurance company as they have provided them to me, the owner, directly.

I (animal owner) hereby authorize Champion Chiropractic to examine and treat my animal(s). I certify my animal has had routine and current veterinary care and that I have been open and honest as to any and all other examinations, diagnoses, and treatments for my animal's condition.

Signature: _____ Date: _____

Print name: _____

Address: _____

Phone: _____ Email: _____

How did you hear about us? _____

Do we have permission to post pictures/video of your animal on social media? _____Y _____N

Dr. Colleen Krahl, DC, CAC
(480) 595-0001
info@championcavecreek.com

NEW PATIENT INFORMATION

Animal's name: _____ Social media handle: _____

Animal's birth date: _____ Spay/neuter (date): _____

Your animal's breed/color/weight: _____

Date of last known rabies / coggins: _____

Does this pet have history of abuse or are they nervous/reactive? _____

Date / provider of your animal's last adjustment: _____

Reason for seeking treatment / what caused this and for how long has it been happening:

_____

_____

Current medical conditions, previous accidents & injuries (please date):

_____

_____

Previous surgical procedures or imaging (please date and specify):

_____

_____

Current medications / supplements (please provide dosage):

_____

_____

Current diet & frequency of feeding:

_____

Activity level / do you compete with this animal:

_____

Other members of animal care team (provide email if you'd like them to receive records):

_____

((Horse owners only)) Trainer & boarding barn contact and address:

_____

VETERINARIAN's Name and Contact Information:

_____

_____