NAME: ____**HOME PHONE**: _______________**CELL PHONE**:________________

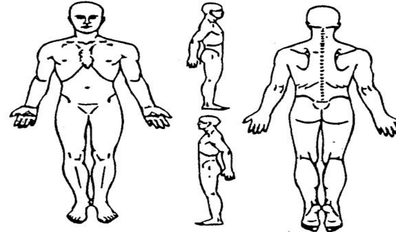
ADDRESS: ____**CITY/STATE/ZIP**: _________________________________

D**OB:** ________________ **CONTACT PHONE**: ____________________________**EMERGENCY CONTACT**: _____________________

Email address (to receive appointment reminders and special offers): ____

**your email and contact information will not be sold to third party **

Please indicate on **DIAGRAM**
areas of focused ATTENTION



PLEASE MARK ALL CURENT AND PAST CONDTIONS:

□ Contagious Skin Condition	□ Heart Condition	□ Cancer
□ Open Sores or Wounds	□ Pacemaker	□ Diabetes
□ Easy Bruising	□ High / Low Blood Pressure	□ Numbness
□ Recent Accident / Injury	□ Circulatory Disorder	□ Back / Neck Issues
□ Recent Fracture	□ Varicose Veins	□ Fibromyalgia
□ Recent Surgery	□ Atherosclerosis	□ TMJ
□ Joint Replacement	□ Phlebitis	□ Carpel Tunnel
□ Sprains / Strains	□ Blood Clots / Joint Disorder	□ Tennis Elbow
□ Current Fever / Chills	□ Osteoporosis	□ Frozen Shoulder
□ Swollen Glands	□ Epilepsy	□ Swelling (where)____________________________
□ Allergies / Sensitivities	□ Headaches / Migraines	□ Pregnant (how many months__________________

Please explain any checked conditions listed above and anything else you think your provider should be aware of: ______________________

____

Please list any medication prescribed or you are currently taking you think you provider should be aware of :_________________________

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DISCLAIMER: This place of business will not be held liable for any injury or condition that arises from services provided despite completion of this form. I agree to communicate with my provider any time I feel as though my well-being is being compromised. I understand that the providers do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, or pharmaceuticals. I acknowledge that these services are not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary Health Care provider for that service. I have stated all medical conditions that I am aware of, and will update the provider of any changes in my health status. I understand that the massage therapists, acupuncturist and exercise therapist have current credentials and that by law they have the right to refuse service on any client at any time, if they feel as though their well-being is compromised.

I understand and voluntarily accept the risks associated with the massage, acupuncture, injections, laser therapy, exercise therapy and/or any other services. I give my permission to receive such services. Except where prohibited by law; I acknowledge and voluntarily assume the risk of injury, accident or death which may arise from massage, acupuncture, laser, injections, exercise therapy and any other services. I understand the importance of informing my provider of all medical conditions and medication I am taking, and to let the provider know about any changes to these. I agree Legacy Clinic will not be liable for death or any injury, including, without limitation, personal, bodily or mental injury, economic loss or damage to me resulting from negligence, using the services of the facilities of Legacy Clinic, to the fullest extent permitted by law. Myself and/or any of my heirs, executors, representatives, or assignees hereby release Legacy Clinic from all claims or liabilities for death, personal injury or property loss or damages of any kind sustained while on the premises, during any services provided by an employee, independent contractor or any representative of Legacy Clinic. I agree that this application and waiver is in effect for all massages, acupuncture, laser, injections, exercise therapy or any other services, and will not expire unless specifically requested by either party. I have been given a chance to ask questions about services agreed to and my questions have been answered.
I understand that Legacy Clinic professional environment and that any inappropriate behavior may result in termination of my services and full payment is expected. By signing this form, I agree to the above terms and release Legacy Clinic and its employees from any liability.

I AGREE TO GIVE AT LEAST 24 HOURS NOTICE OF CANCELLATION OF APPT., OTHERWISE I WILL BE EXPECTED TO PAY . PLEASE INITIAL __________

LEGAL RELATIONSHIP BETWEEN FACILITY AND ACUPUNCTURIST or MASSAGE THERAPIST or TRAINER
I understand that the contractor providing services including acupuncture, homeopathic injections, personal training, laser, ozone injections, massage therapy has its own risks. Legacy Clinic's Acupuncturist, Massage Therapist, and personal trainers are independent contractors with the patient and are employees or agents of Legacy Clinic of Chiropractic. As such, these various independent contractors provide their own liability protection and malpract insurance. Legacy Clinic of Chiropractic is not responsible for liability of independent contractors. All liability claims need to be addressed to the independent contractor or the contractors limited liability company.

Client signature______________________________________Date_____________________