EAST WIND ACUPUNCTURE

traditional chinese medicine clinic

Massage & Bodywork
New Patient Intake Form
(Confidential Information)

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Primary Care Provider: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Phone (home): _____ Work: _____ Cell/Pager: _____

Referred by: _____

Current Health:

Have you received massage therapy before? _____ Yes _____ No Frequency: _____

Type of Massage received? _____ Deep Tissue _____ Swedish _____ Therapeutic _____ Sports _____ Other

Reason for today's visit: _____

Desired result of today's session: _____

Have you received treatment for this before? _____ Yes _____ No

Explain: _____

_____

List Activities Affected: _____

Are you currently under the care of a physician? _____ Yes _____ No

Current Medications / Herbs: _____

Stress Reduction / Relaxation / Exercise Activities: _____

Please indicate your consumption of the following on a scale of 0-5 (5 being heavy):

☐ Salt ☐ Sugar ☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Exercise ☐ Water

Do you have a History of any of the following

☐ Accident
☐ Neck Pain
☐ Whiplash
☐ Headaches
☐ Dizziness
☐ Anxiety
☐ Depression
☐ Disc Problems
☐ Broken Bones
☐ Arthritis / Bursitis/Gout
☐ Rash
☐ Hepatitis
☐ Mid Back Pain
☐ Low Back Pain
☐ Joint Ache
☐ Decreased Range of Motion
☐ Sprains
☐ Epilepsy / Seizures
☐ Abdominal Pain
☐ Nervous Tension
☐ Surgery
☐ Wear Contacts
☐ Edema
☐ Fainting
☐ Fibromyalgia
☐ Implants / Prosthetics
☐ Varicose Veins
☐ High Blood Pressure
☐ Diabetes
☐ Heart Attack
☐ Low Blood Pressure
☐ Stroke
☐ Heart Conditions
☐ Cancer
☐ Colitis
☐ HIV/AIDS
☐ Recent Injury or Trauma

Explain: _____

_____

Allergies or Sensitivities

☐ Oils ☐ Lotions ☐ Scents ☐ Detergents ☐ Foods

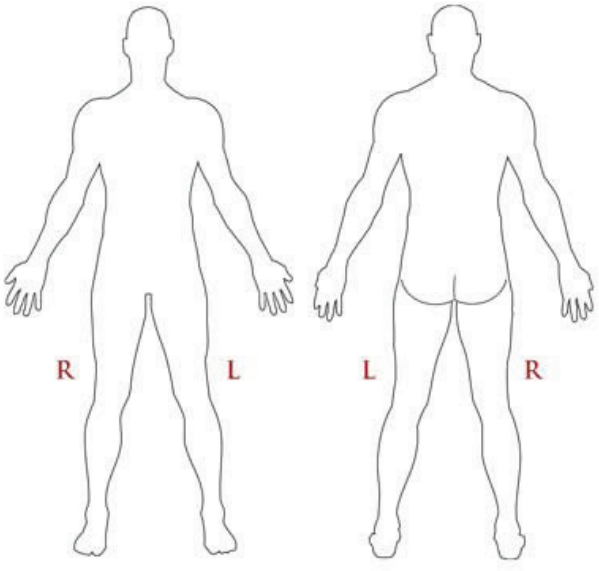
☐ Other: _____

Do you have any of the following today?

☐ Pregnancy: If so, How far along are you? _____ Due Date: _____

☐ Inflammation ☐ Skin Rash ☐ Headache ☐ Sunburn / Poison Ivy
☐ Severe Pain ☐ Open Cuts / Bruises / Burns ☐ Cold / Flu

Please indicate with an (X) the places you are feeling discomfort



FRONT BACK

Consent for Care:

It is my choice to receive Massage Therapy. I understand the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature: _____

Date: _____