



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

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

Explain: _____

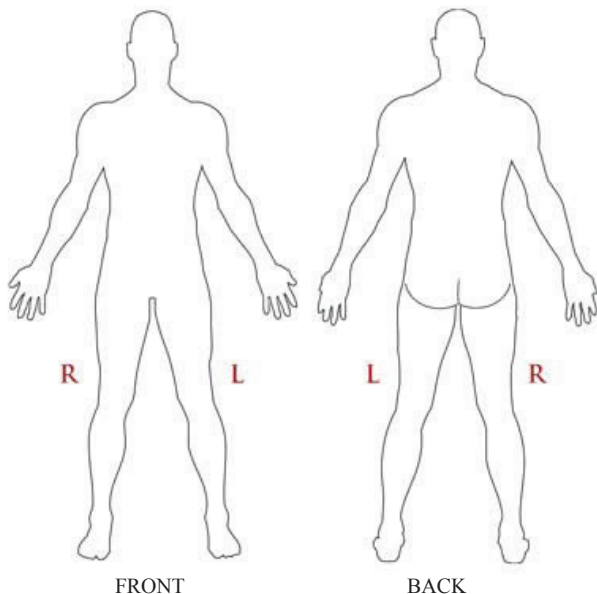
Allergies or Sensitivities

- 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



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: _____