CHI WELLNESS

Chi Wellness Client Health Information Intake Form

First Name: _____M.I. _____ Last Name:_____

Address: _____City: _____ State: _____

Zip: _____Phone(h): (_____)_____-_____ (c) (_____)_____-_____ Date of Birth:___/___/____(mm/dd/yyyy)

Employer: _____ Occupation:_____

Emergency contact: _____ Phone: _____ Relationship:_____

Referred by:_____ E-mail:_____

Are you currently pregnant? Yes__ No__ If so, how far along are you? _____

Do you believe in natural remedies such as herbs? Yes_____ No ____

Is this your first professional medical massage (including acupuncture, aroma therapy, cupping, guasha)? (Yes / No)

If no, how frequently do you get a massage? _____

What do you hope to accomplish from today's massage?_____

Are you aware of any tension holding spots in your body? _____ If yes, please list out the location(s):

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Are you nervous about needles? (Yes / No) Do you have a tendency to faint? (Yes / No)

Do you bleed for a long time or bruise easily? (Yes / No) Are you taking blood thinners? (Yes / No)

Do you have low blood pressure? (Yes / No) Do you have high blood pressure? (Yes / No)

Is your immune system compromised by diabetes? (Yes / No)

Is your immune system compromised by autoimmune disease? (Yes / No)

Are you taking any autoimmune suppressant? (Yes / No)

Do you have any infectious diseases? (Yes / No)

If yes, please identify_____

Do you have pacemaker or other electrical implant? (Yes / No) Do you have Bleeding disorder? (Yes / No)

Do you have a damaged heart valve or prosthetic valve? (Yes / No)

Describe any surgeries, hospitalizations, accidents or injuries you have had: Please write down month/year:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

What kind of care did you receive for your accidents or injuries?_____

_____

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Do you feel that you have recovered from these events?_____

_____

Do you have any chronic, ongoing pain that you deal with on a regular basis?_____

Have you been given a diagnosis for any current medical issues. Yes____ No____

Describe what activities cause this pain and/or make it worse:_____

Are you receiving any other type of medical treatment?_____

_____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

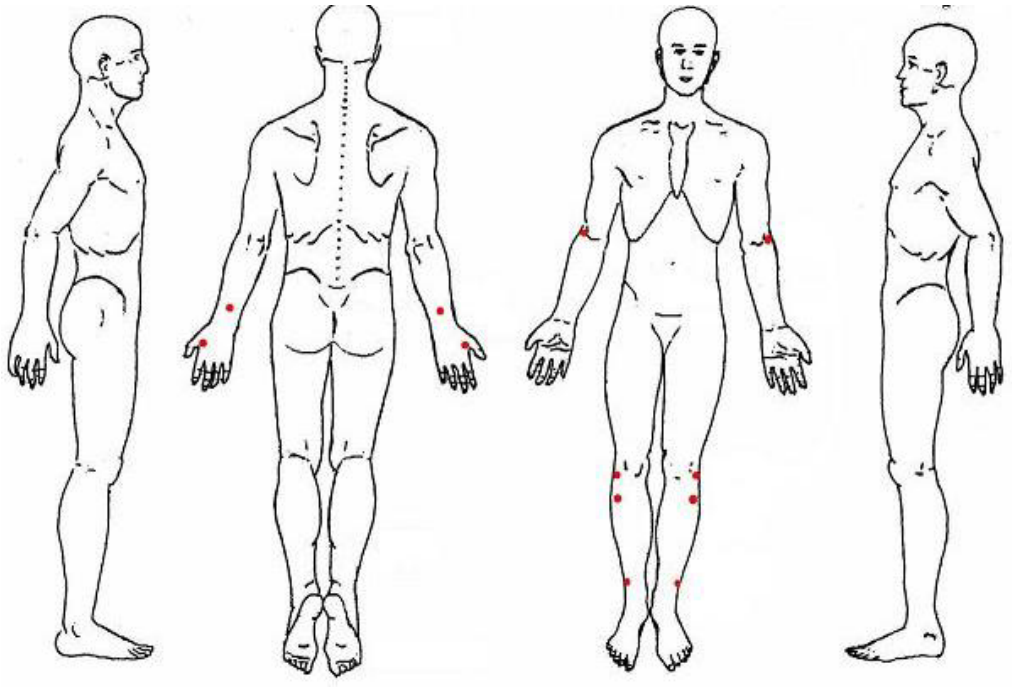
Are you currently under the care of a physician? (Yes/No) Who's your physician?_____

Address:_____

Phone:_____

Please indicate where you experience pain on the drawing below

Right Left



Are you currently experiencing any of the following conditions?

Flu or Cold (Yes / No) Inflammation (Yes / No) Fever (Yes / No) Infection (Yes / No)

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Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL

___ Arm Pain/Shoulder Pain
___ Arthritis/Osteoporosis /Rheumatoid Arthritis
___ Bursitis
___ Cysts
___ Gout
___ Fibromyalgia
___ Headache / Migraines
___ Other _____
___ Thoracic Outlet Syndrome
___ Postural Deviations/ Scoliosis
___ Hip Pain
___ Leg Pain
___ Low Back Pain
___ Mid Back Pain
___ Osteoarthritis/Rheumatoid Arthritis
___ Plantar Fascitis
___ TMJ
___ Spasms/Cramps
___ Sprains/Strains
___ Tendinitis
___ Torticollis
___ Whiplash Syndrome

SKIN

___ Acne
___ Athletes Foot
___ Dermatitis/Eczema
___ Fungal Infections
___ Hives
___ Impetigo
___ Itching
___ Open Wound or Sore
___ Psoriasis
___ Rashes
___ Warts/Moles
___ Other _____

NERVOUS SYSTEM

___ ALS
___ Bell's Palsy
___ Carpal Tunnel Syndrome ___ Multiple Sclerosis
___ Neuritis
___ Numbness/Tingling/Twitching
___ Parkinson's Disease
___ Sciatica
___ Seizure Disorders
___ Spinal Cord Injury
___ Stroke
___ Tremors
___ Trigeminal Neuralgia
___ Other _____

RESPIRATORY

___ Asthma
___ Bronchitis
___ COPD
___ Dizziness
___ Pneumonia
___ Sinusitis
___ Trouble Breathing
___ Other _____

DIGESTIVE

___ Colitis
___ Crohn's Disease
___ Diarrhea
___ Gallstones
___ Gas/Bloating
___ Hepatitis
___ Indigestion
___ Irritable Bowel Syndrome
___ Liver disease
___ Pancreatitis
___ Ulcers
___ Other _____

CIRCULATORY

___ Anemia
___ Arrhythmias
___ Blood Clots/Phlebitis
___ Diabetes
___ Edema
___ Heart Condition/ Heart burn
___ Heart Mummers/ Palpitations
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Nose Bleeds
___ Raynaud's Disease
___ Varicose Veins
___ Other _____

OTHER

___ Anxiety/Panic Attacks
___ Autoimmune Disease
___ Bladder Infection
___ Cancer
___ Depression
___ Eyestrain/pain
___ Grief Process
___ HIV/AIDS
___ Insomnia
___ Kidney Disease
___ Lupus
___ Night blindness
___ PMS
___ Postoperative Situation
___ Pregnancy
___ Sleep Apnea
___ Substance Abuse
___ Other _____

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I confirm the above information is accurate and true to the best of my knowledge. I understand that massage therapists and acupuncture therapist do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy and/or acupuncture therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that canceled or missed appointments without 48 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Acupuncture needles and herbal ball therapy are used once and properly disposed of for the safety of our clients. Cupping is cleaned thoroughly after each session.

Signature: _____ **Date:** _____

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