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Confidential Intake Form

Name _____ Today's Date _____

What condition(s) would you like to have treated? _____

How long have you had this/these condition(s)? _____

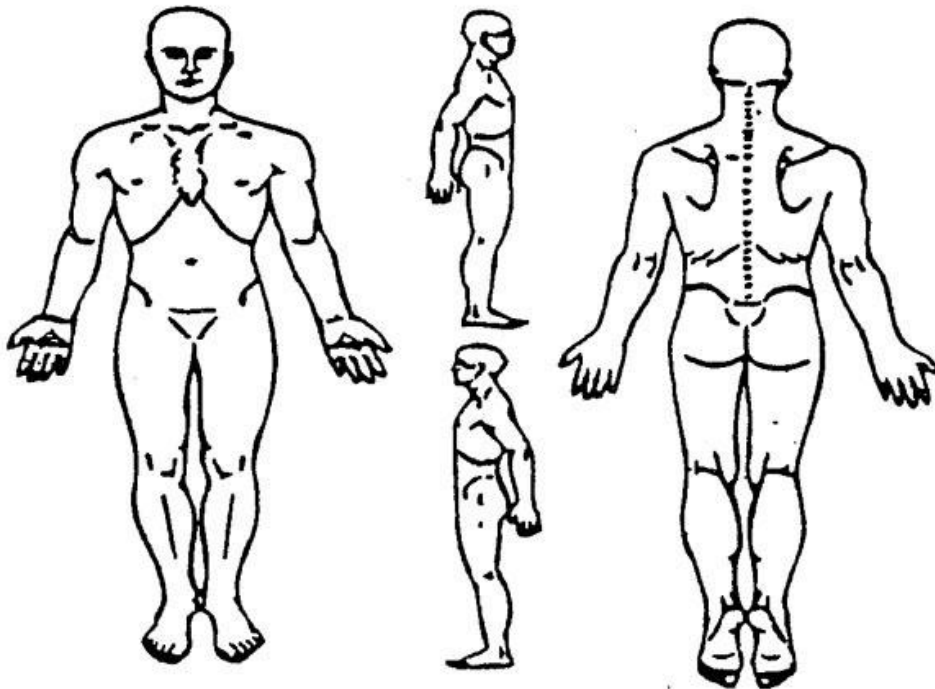
What medical diagnosis have you received for this/these condition(s)? _____

What other treatments have you received for this/these condition(s) _____

Please list any prescription medications you are currently on _____

Please list any supplements or herbs you are regularly taking _____

On the following drawings shade the areas where you feel pain or indicate the areas that you would like to address.



Have you had or do you currently have any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Allergies (food/latex) | <input type="checkbox"/> Heart condition (i.e. Pacemaker) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lymph nodes removed |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other: _____ |

Date	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you currently have a primary care physician (MD/ND)? yes no
If yes, please give their name and location _____

Are you currently pregnant? yes no
Is there anything else that you would like to tell me about yourself that I have not
addressed in this form? _____

I have listed all my known medical conditions and physical limitations and will inform the practitioner in writing of any change in my physical health between treatments. I understand that the practitioner must be aware of any and all existing physical conditions that I have in order to provide appropriate treatment. I further understand that an acupuncturist/massage practitioner neither diagnoses nor prescribes pharmaceutical drugs for illness, disease, or any other medical, physical, or emotional disorder, nor performs any thrusting joint spinal manipulations. I agree to give 24 hour notice if I must cancel my appointment(s). I have carefully read and I understand all of the foregoing, and so I am fully aware of what I am signing.

Signature _____
Date