Client Intake Form

ASH
Chiropractic & Wellness

Member Information

Member Name: _____	Date of Birth/Age: _____
Address: _____	Email: _____
Is this your first cupping session? _____ What is your primary goal for today's session? _____	
List any conventional or unconventional medications, herbs and therapies you are currently trying: _____ _____	

Medical Information

Please mark "C" next to current or chronic issues and mark "P" next to those you've had in the past

Broken Bone ___	Surgical Incision___	Organ Failure ___	Insulin Monitor ___	Cancer ___
Varicose Veins ___	Pregnancy ___	Skin Disease ___	Appendix ___	Hernia ___
Dislocation ___	Hemophilia ___	Hearing Aid ___	Slipped Disc ___	Fever ___
Diabetes ___	Blood Thinner ___	Sunburn ___	Kidney Illness ___	Blood Pressure ___
Ulcerated Skin ___	Cardiopathy ___	Pacemaker ___	Joint or Bone Replacement ___	

List any major illnesses: (What age?) _____

List any major broken bones (What age?) _____

List any surgeries (What age?) _____

List any major hospitalizations (What age?) _____

Check all that apply today o Fever o Infection o Cold/Flu o Inflammation o Pregnant/trying

I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to my therapist any physical discomfort during the session. Information has been provided to me about massage cupping techniques. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations. It has been explained to me the possibility of discolorations that can occur from the release and clearing of stagnation and toxins. I also understand that this reaction is not bruising. I further understand that the discolorations will dissipate within a few hours to as long as a week in some cases, and in relation to my after-care activities. I understand that cupping modalities should not be combined with aggressive exfoliation. I understand that I should avoid hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. I also understand that I should avoid excess caffeine and alcohol and I should consume plenty of clean drinking water.

Client: _____	
Client Signature: _____	Date: _____

Consent to Treatment of Minor: By signature below, I hereby authorize Ash Chiropractic & Wellness to Administer massage, bodywork or facial to my child or dependent as they deem necessary.

Signature of Parent/Guardian _____
Date: _____