



Therapeutic Acupressure Client Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a health profile for you. All of your answers are confidential. If you have any questions, please ask.

Today's Date: _____

Name: _____

Date of Birth: _____ Gender: M F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: Cellular _____ Home _____

Email address: _____

Occupation: _____ Employer/School: _____

Marital Status: Married Single Divorced Widowed Children Yes No

Emergency Contact: _____ Relationship: _____ Telephone #: _____

How did you hear about us? _____

If referred, please write your initials here to give us permission to thank this person: _____

Have you received therapeutic acupressure therapy before? Yes No If yes, date of last session: _____

Females only: Are you pregnant or trying to become pregnant ? Yes No

Please initial here: _____

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Client Name: _____

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Main complaint (Symptom(s), diagnosis, duration of condition, etc.): _____

Recent injuries: Please describe: _____

Surgeries: Please include type and date of procedure: _____

Automobile/vehicle accidents: Please include date(s) and types: _____

Significant trauma (Fall, head injury, psychological, etc.): _____

Allergies (Food, drug, chemical, environmental): _____

Diet: Meals per Day _____ Snacks _____ Caffeinated Drinks/Day _____ Alcohol Drinks/Week _____

Medications: Please attach additional page if necessary: _____

Vitamins/supplements/herbs: Please attach additional page if necessary: _____

Exercise: Days per week _____ Length of Workout _____ Type of Activity _____

Sleep pattern: # Hours per night _____ Quality of Sleep _____

Do you experience stress in your work, family, or other aspect of your life? Yes No

Indicate on the scale your satisfaction in family relationships: Satisfied -----Distressed

Indicate on the scale your satisfaction in working relationships: Satisfied -----Distressed

What are you looking to accomplish through therapeutic acupressure sessions?

Client agreement

It is my choice to receive therapeutic acupressure. I am aware of the benefits and risks of therapeutic acupressure and give my consent for therapeutic acupressure. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that therapeutic acupressure 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. I understand that this form is for information purposes only for the practitioner to better understand my health constitution.

Signature: _____ Date: _____