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CUPPING AND GUA SHA NEW PATIENT INFORMATION

Information obtained here is confidential and will not be released to any person(s), except upon your written consent to do so.

Today's Date: _____/_____/_____

GENERAL INFORMATION

Legal Name _____ Preferred Name/Nickname _____

Date of Birth _____ Gender Identity/Pronoun(s) _____

Address _____ City _____ State _____ Zip Code _____

Preferred Phone Number (_____)_____ Ok to leave a medical related voicemail at this number? ____Y ____ N

Email address _____ Ok to send medical related messages to this email? ____Y ____ N

Occupation(s) _____

Minors Under 18 - Parent/Responsible Party Information

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number (_____)_____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Phone Number (_____)_____

HEALTH INFORMATION

Are you pregnant? ____Y ____ N If yes, how many weeks? _____ Are you breastfeeding? ____Y ____ N

Do you smoke or vape? ____Y ____ N ____ Former If yes, what, and how much/how often per day?_____

Do you have Botox or fillers? ____Y ____ N If yes, how long ago was your last session? _____

Describe your general health: _____

List all medications, herbs or supplements you are currently taking: _____

_____

List any major illnesses, hospitalizations or surgeries _____

_____

List any allergies to liniments, lotions, ointments, oils, essential oils, nuts, etc. _____

_____

List any experience with professional bodywork (chiropractic, massage, acupuncture, etc.) _____

_____

Previous experience with cupping or gua sha? _____Y _____N If yes, how long ago? _____

Are you sensitive to touch or pressure in any area? _____Y _____N If yes, what area(s)? _____

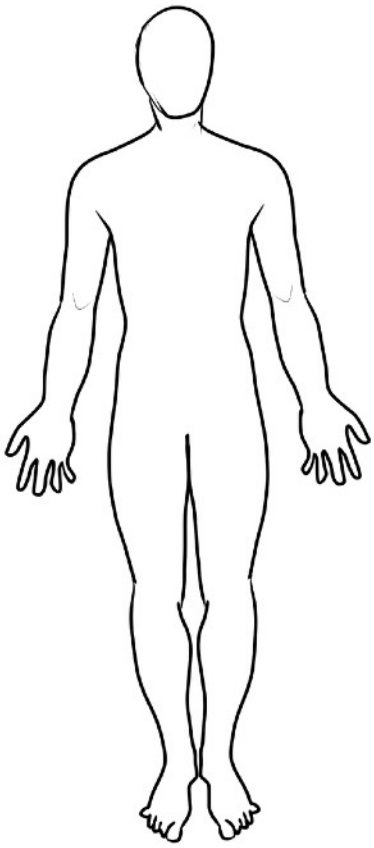
Is there anything about your health history that you think would be useful for me to know in order to plan a safe & effective session for you?

_____

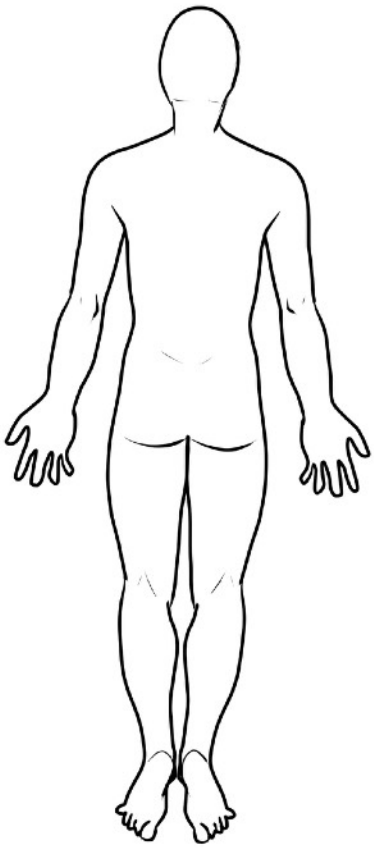
There are contraindications for cupping and gua sha. Please check the box to any of the following conditions that may apply to you:

- ☐ Cancer
- ☐ Current chemotherapy
- ☐ Easy bruising
- ☐ Current infection/cold/flu
- ☐ Sprains/strains
- ☐ Hemophilia
- ☐ Taking blood thinners
- ☐ Decreased sensation or numbness in areas
- ☐ Joint replacement
- ☐ Asthma
- ☐ Sensitive skin (easily irritated)
- ☐ Thin skin (tears easily)
- ☐ Contagious skin condition
- ☐ Eczema
- ☐ Broken skin/open wounds
- ☐ Cardiovascular condition
- ☐ Pacemaker
- ☐ Kidney disease or stones
- ☐ Sunburn or burn
- ☐ Varicose veins
- ☐ Lung conditions
- ☐ Pregnancy
- ☐ Vertigo
- ☐ Diabetes
- ☐ Fever or Chills
- ☐ High/Low blood pressure
- ☐ Seasonal allergies
- ☐ Joint disorder
- ☐ Rheumatoid arthritis
- ☐ Organ failure
- ☐ Hernia
- ☐ Deep vein thrombosis or blood clots
- ☐ Recent fracture or broken bone
- ☐ Lymphatic illness
- ☐ Epilepsy or seizures
- ☐ Other: _____

Please circle any areas of pain or discomfort, then next to that area, please describe in words how it feels.



Front of body



Back of body

What is your primary goal for today's session? _____