ACUPUNCTURE & WELLNESS CENTER

HEALING TOUCH INTAKE FORM | JEAN WIBLE

This questionnaire is CONFIDENTAL and used to gather information to give you the most effective treatment possible.

Name: _____Phone Home _____ Cell _____

Address: _____ City _____State_____ Zip _____

Email _____Birth date _____ Age_____ Sex _____ Marital Status _____

Occupation_____ Referred by_____

Emergency Contact_____Relationship_____Phone_____

Have you ever received Energy Work? ❍ Yes ❍ No Type: ❍ Acupuncture ❍ Reiki ❍_____

Medications, Herbs or Supplements you are presently taking:_____

Are you or might you be pregnant? ❍ Yes ❍ No ❍ Not Sure

Have you consumed alcohol in the past 24 hours? ❍ Yes ❍ No

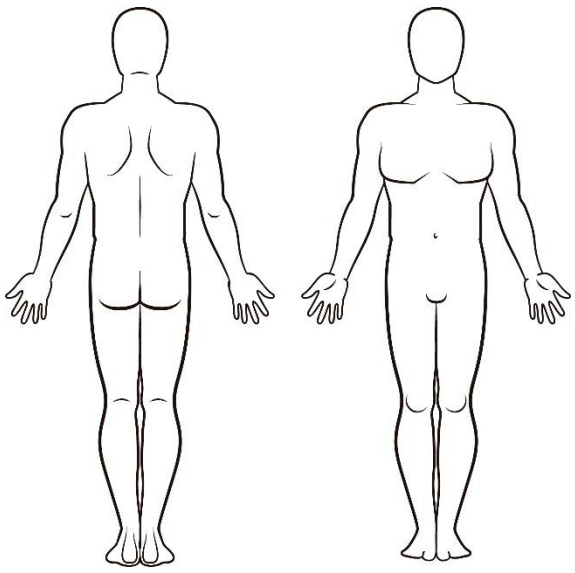
Please indicate your consumption level:

	None	Light	Moderate	Heavy
salt	❍	❍	❍	❍
sugar	❍	❍	❍	❍
caffeine	❍	❍	❍	❍
tobacco	❍	❍	❍	❍
alcohol	❍	❍	❍	❍
exercise	❍	❍	❍	❍
water	❍	❍	❍	❍

Do you have a history of the following? (Check all that apply)

❍ accident
❍ neck pain
❍ whiplash
❍ headaches
❍ shoulder pain
❍ upper back pain
❍ mid back pain
❍ low back pain
❍ joint ache
❍ decreased range of motion
❍ broken bones
❍ sciatica
❍ sprains
❍ seizures
❍ abdominal pain
❍ nervous tension
❍ arthritis, bursitis or gout
❍ allergies to oils or perfumes
❍ wear contacts
❍ scoliosis
❍ surgery
❍ fibromyalgia
❍ carpal tunnel syndrome
❍ mastectomy
❍ breast augmentation
❍ diabetes
❍ varicose veins
❍ high blood pressure
❍ stroke
❍ heart attack
❍ cancer
❍ colitis
❍ HIV
❍_____
_____

PLEASE INDICATE WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT



Do you have any of the following today?

❍ sunburn
❍ inflammation
❍ severe pain
❍ headache
❍ open cuts, bruises, burns
❍ irritated skin rash
❍ poison ivy
❍ cold/flu

What are your goals/expectations for this session?

_____

_____

_____

_____