

Confidential Client Profile

Name: _____ D.O.B. _____
 Address: _____ City/State _____ Zip Code: _____
 Phone Nos: _____ () Cell () Office () Home
 Email: _____

Occupation: _____ Referred by: _____

Marital Status Single Married Divorced Widowed Number of Children: _____

1. Have you had a professional Massage or Acupuncture before: Yes No Reason: _____
 Frequency: _____ Results/Satisfaction: _____

2. What is the reason for today's visit: _____

What part of body is to be worked on: _____

3. Health History. *Please check all that apply (or fill in a condition not listed)*

- | | | | | |
|--------------------------------------|--|---|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Headache | <input type="checkbox"/> Joint Pain/Stiff | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Blood Pres | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine Pain | |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Neck | |

4. Have you had an automobile or other accident causing physical injury. No Yes When: _____

5. Have you had any surgeries: No Yes If yes, when and why: _____

6. What medications do you take: _____

7. Do you smoke: No Yes How much per day _____ No. of years: _____

8. Do you drink alcoholic beverages: No Yes

9. How would you rate your current diet: Excellent Good Fair Poor Unsure

10. Emergency Contact/Relationship: _____ Phone No.: _____

Informed Consent: I hereby request and consent to the treatments and other procedures within the scope of practice by Art of Healing Inc. on me, There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. If heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile and Clean Needle Technique procedures are followed. I understand that all practitioners at Art of Healing Inc. are certified in Clean Needle Technique and use only sterile, single-use, disposable needles.

24 Hour Cancellation Policy: If you need to cancel or reschedule your appointment with Art of Healing Inc., please call or email at least 24 hours in advance. Since availability is limited, you will be charged in full for your session if notice of cancellation is not given 24 hours in advance, or if you miss your appointment without notice. We value your time, so please value ours as well.

Signature: _____

Date: _____