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CUPPING AND GUA SHA NEW CLIENT 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 (_____)_____

Healthcare Information

Are you pregnant? _____Y _____N If yes, how many weeks? _____ Do you smoke or vape? _____Y _____N _____Former

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 (blood thinners, painkillers, antibiotics, antidepressants, multivitamin, etc.)

_____

_____

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?

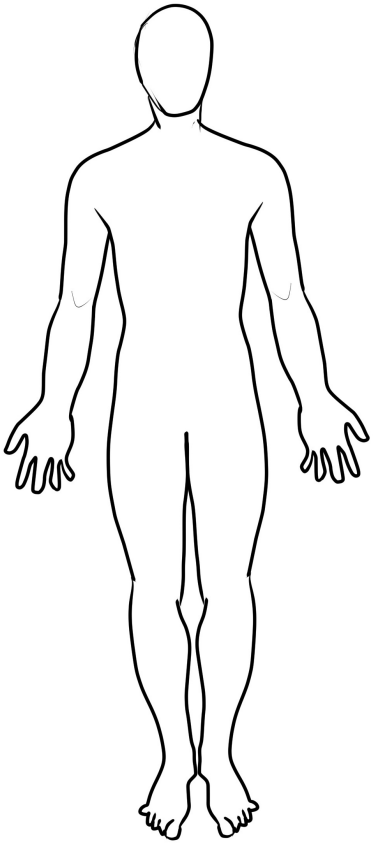
_____

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

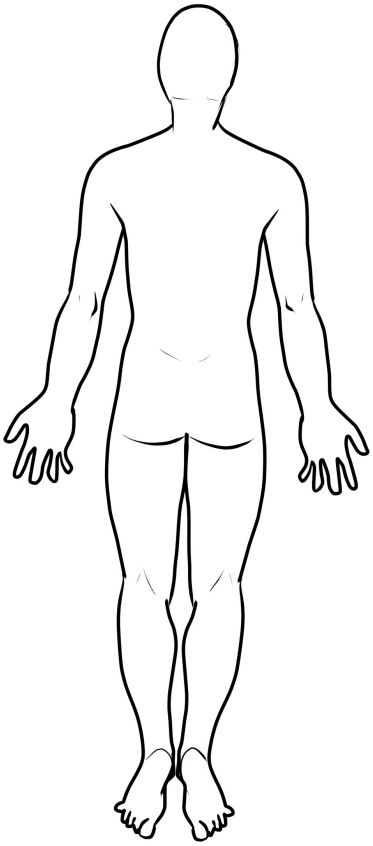
There are contraindications for cupping and gua sha. Please check the box to any of the following conditions that may apply to you:

- ☐ Cancer
- ☐ Current chemotherapy
- ☐ Easy bruising
- ☐ Current infection/cold/flu
- ☐ Sprains/strains
- ☐ Hemophilia
- ☐ Taking blood thinners
- ☐ Decreased sensation or numbness in areas
- ☐ Joint replacement
- ☐ 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
- ☐ Asthma
- ☐ 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