



## INTEGRATIVE HEALTH SERVICES REGISTRATION FORM

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about our integrative Programs?  E-mail Announcements  Referring Physician (name) \_\_\_\_\_  Online  Family/Friend  Other \_\_\_\_\_  Print/Flyer \_\_\_\_\_

Appointment Type  Acupuncture  EFT  Myofascial Release  Biofeedback  Lymphatic Drainage  Reiki  Craniosacral Therapy  Massage  Yoga  Meditation  T'ai Chi

What are the symptoms/problems for which you are seeking treatment? And what are you hoping to get out of treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you received a diagnosis from a doctor for your concerns? If yes, what was the diagnosis? \_\_\_\_\_  
\_\_\_\_\_

What kinds of treatment(s) have you tried or are currently using related to these concerns? \_\_\_\_\_  
\_\_\_\_\_

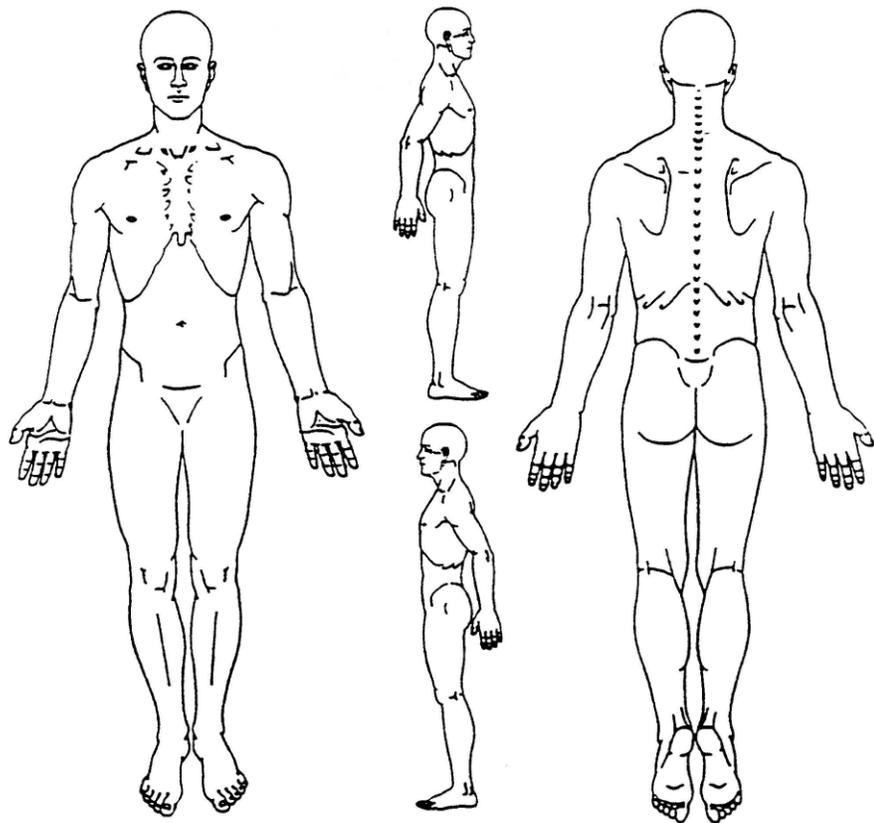
If there is pain, please describe it: \_\_\_\_\_

### Please check if you have any of the following conditions:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Surgery type: _____  |
| <input type="checkbox"/> Anxiety/Depression                                 | <input type="checkbox"/> Headaches             | _____   |
| <input type="checkbox"/> Balance problems/Falls                             | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Bleeding/Bruising                                  | <input type="checkbox"/> Joint Problems        | <input type="checkbox"/> Seizures/Epilepsy    |
| <input type="checkbox"/> Blood Pressure Problems                            | <input type="checkbox"/> Lymphedema            | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Bursitis   | <input type="checkbox"/> Muscle Strain/Sprain  | <input type="checkbox"/> Skin Conditions      |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Phlebitis/Blood Clots | <input type="checkbox"/> Spine Problems       |
| <input type="checkbox"/> Cardiac Issues (if yes, Pace Maker/Defibrillator?) | <input type="checkbox"/> Pregnancy week: _____ | <input type="checkbox"/> Stress               |
| <input type="checkbox"/> Circulation Problems                               | Complications: (i.e. bleeding, cramping) _____ | <input type="checkbox"/> Varicose Veins       |
| <input type="checkbox"/> Diabetes   | _____  |   |

PLEASE COMPLETE BOTH SIDES

Please use the diagram to indicate the symptoms you have experienced.



Medications \_\_\_\_\_

Allergies (i.e. meds, nuts, bees, scents, etc) \_\_\_\_\_

Please give us any details you wish to provide regarding the conditions checked off.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I hereby authorize the above mentioned Integrative Services to be provided by the Spaulding Rehabilitation Hospital Network Clinicians. I know the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me to as to the result of treatment(s) or examinations. If I experience any pain or discomfort during treatment, I will immediately inform the practitioner, so treatment can be adjusted. I affirm that I have stated all known medical conditions and answered all questions honestly. I realize that the Integrative Medicine Service is a self-pay program and I will provide payment at the time of visit.**

Signature \_\_\_\_\_ Date \_\_\_\_\_