INTEGRATIVE HEALTH SERVICES
REGISTRATION FORM

Today’s Date: ______________________________________

Name ____________________________________________

Emergency Contact __________________________________ Phone #: ____________________________

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

Appointment Type
□ Acupuncture □ EFT
□ Biofeedback □ Lymphatic Drainage
□ Craniosacral Therapy □ Massage
□ Meditation □ Myofascial Release
□ Reiki □ Yoga
□ 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:

□ Arthritis □ Dizziness □ Surgery type: ______
□ Anxiety/Depression □ Headaches □ Respiratory Problems
□ Balance problems/Falls □ Hernia □ Seizures/Epilepsy
□ Bleeding/bruising □ Joint Problems □ Sinus Problems
□ Blood Pressure Problems □ Lymphedema □ Skin Conditions
□ Bursitis □ Muscle Strain/Sprain □ Spine Problems
□ Cancer □ Phlebitis/Blood Clots □ Stress
□ Cardiac Issues (if yes, Pacemaker/Defibrillator?) □ Pregnancy week: ____
□ Complications: (i.e. bleeding, cramping) ____
□ Circulation Problems □ 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)_______________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

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 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 ________________________