



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? _____

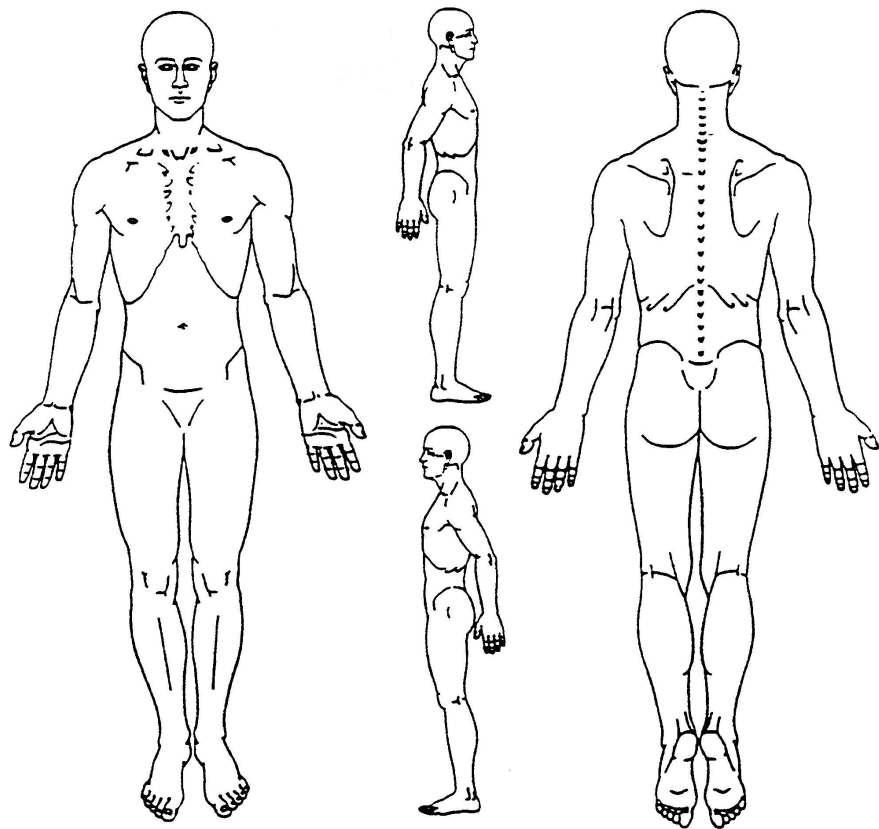
If there is pain, please describe it: _____

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 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 _____