SPAULDING REHABILITATION HOSPITAL NETWORK
AMBULATORY SERVICES

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
- ☐ Print/Flyer
- ☐ Referring Physician (name) _____
- ☐ Online
- ☐ Other _____

Appointment Type

- ☐ Acupuncture
- ☐ Biofeedback
- ☐ Craniosacral Therapy
- ☐ EFT
- ☐ Lymphatic Drainage
- ☐ 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? _____

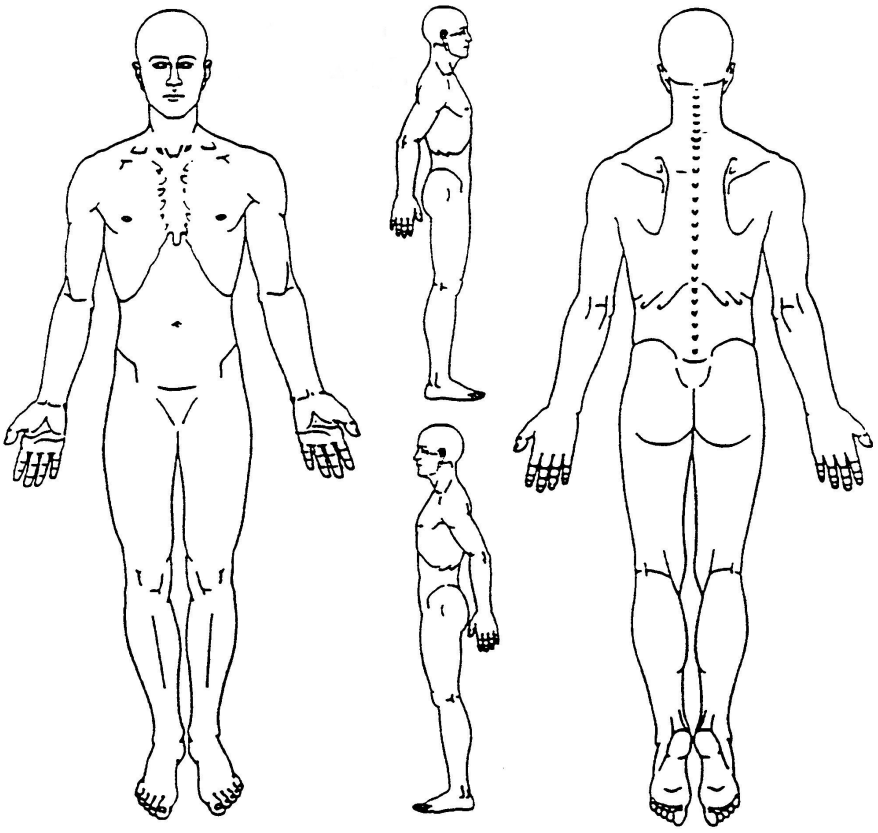
If there is pain, please describe it: _____

Please check if you have any of the following conditions:

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

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** _____

PLEASE COMPLETE BOTH SIDES