Tibetan Medicine & Holistic Healing
Clinic Intake Form~ Consults & Kunye Massage

Medical History is confidential, though may be shared with primary care physician or specialist with permission

Name ____**Today's Date**_________

Address____

City ____ **State** _______ **Zip** ___________

Date of Birth __________ **Age** ____ **e-mail** ____________________________________

Home Phone__________________________**Cell Phone** ___________________________

***Primary Care Physician Name and Phone*:** ____

***Referred by*:** ____

For Kunye Tibetan Massage - what level of pressure do you prefer? *Light *Medium *Deep

Do you have an allergies or sensitivity to oils or scents?

Are there limitations to your movements, muscle injury or any issues that I should be aware of before you receive bodywork?

Major Complaint: What is your primary reason/s for coming for Tibetan Medicine?

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-

Are there times, seasons or things which aggravate symptoms?

Are there things which help your symptoms?

Personal History:

Please check all conditions you currently have or have had in the past: ***C for current P for Past***

- [ ] AIDS/ HIV
- [ ] Allergies
- [ ] Alcoholism
- [ ] Anemia
- [ ] Antibiotic Use
- [ ] Asthma
- [ ] Anxiety
- [ ] Autoimmune
- [ ] Bleeding Easily
- [ ] Bruising Easily
- [ ] Cancers
- [ ] Celiacs Disease
- [ ] Chicken Pox
- [ ] High Cholesterol
- [ ] Diabetes
- [ ] Depression
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Menstrual Irregularity
- [ ] Mental Illness
- [ ] Multiple Sclerosis
- [ ] Night Sweats
- [ ] Neurological Disorder
- [ ] Pertussis / Whooping Cough
- [ ] Pneumonia
- [ ] Obesity
- [ ] Rheumatic Fever
- [ ] Scoliosis
- [ ] Stroke
- [ ] Thyroid
- [ ] Vascular Disease

Other____________________

Family History:

Please check all that apply and who: ***F-****father,* ***M****-mother,* ***PG****- or* ***MG-****p/m-grandparent,* ***S****-sibling,* ***C****-child*

- ☐ AIDS/ HIV
- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Antibiotic Use
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- ☐ Scoliosis
- ☐ Stroke
- ☐ Thyroid
- ☐ Vascular Disease

Other____________________

Over →

Current Medications & Supplements: (Please list all you are taking)

List any surgeries, serious illness, broken bones, injuries, hospitalizations etc.

Allergies: Are you allergic or hypersensitive to any:

Drugs:____

Foods:____

Other:____

Are there any Lab / medical tests that your GP or specialist is tracking regularly?

Cholesterol, Hepatitis, IGG, Mammography, Pap, PSA, Stool?

Over →