INTAKE FORM

Name: ______________________________ Phone #: ____________________

Date of Birth: ______________________________ Email: ____________________

How did you hear about Best Health Option? ______________ Occupation: ____________________
(Word of mouth, Internet, Flyer, ad/article)

What are the reasons for your visit today? ____

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Describe any cuts, bruises, or injuries you currently have: ____________________________

Describe surgeries you have had: ____

List all conditions currently monitored by a Health Care Provider: ____________________
(or other conditions that you feel may be important)

List any medications that you took today: ____

Please check all current and previous conditions:

- ☐ Headache/migraine
- ☐ Sleep problems
- ☐ Fatigue
- ☐ Flu or cold symptoms in the last 48 hours
- ☐ Sinus issues
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Broken bones/sprains
- ☐ Spasms/cramps
- ☐ TMJ (jaw pain)
- ☐ Tendonitis/bursitis
- ☐ Varicose Veins
- ☐ Stiff/painful joints
- ☐ Neck, shoulder, or arm pain or numbness
- ☐ Low back, hip or leg pain or numbness
- ☐ Sciatica
- ☐ Depression
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart disease
- ☐ High/low blood pressure
- ☐ Poor circulation
- ☐ Asthma
- ☐ Thyroid dysfunction
- ☐ Diabetes
- ☐ Currently pregnant
- ☐ Malignant cancer or tumors
- ☐ Benign cancer or tumors

Consent for care: It is my choice to receive ashiatsu, massage therapy, aroma therapy or cupping/gua sha therapy and I give consent to receive treatment. I understand that my practitioner does not diagnose illness, disease or any other physical or mental disorders. The service I am receiving is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Best Health Option practitioner updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Consent to treat a minor child or disabled dependent:
I authorize ____________________ and whomever he/she designates as assistants to administer care as deemed necessary to my ____________________________ (relationship) Patients name ____________________________.
Adult's/guardian's signature______________________________ Date_______________ Time ________________

Patient signature ________________________ **Date** ___________ **Time**___________

Practitioner signature ____________________ **Date** ___________ **Time**___________