KATE BUTT
R.TCM.P
CLIENT INFORMATION

NAME: _____ **DATE**: _____
ADDRESS:_____
AGE: _____ **DATE OF BIRTH**: _____
HOME PHONE: _____ **WORK PHONE**: _____
CELL PHONE: _____ **EMERGENCY CONTACT & PHONE #:** _____
FAMILY DR.: _____
WHO WERE YOU REFFERED BY: _____
OCCUPATION: _____
REASON FOR COMING: _____
_____
MAIN HEALTH CONCERN: _____
_____
HISTORY OF SURGERIES WITH DATES: _____
_____
_____
HISTORY OF TRAUMAS/MAJOR ACCIDENTS WITH DATES:
_____
_____
_____
DO YOU HAVE ANY ALLERGIES? _____
_____
LIST OF CURRENT MEDICATIONS INCLUDING SUPPLEMENTS:
_____
_____
PLEASE CIRCLE ANY SYMPTONS THAT APPLY TO YOU:

headache/migraine poor circulation bloating neck pain anxiety gas

memory loss dizziness back pain depression jaw pain easily bruised

breathlessness constipation diarrhea coughing cankers allergies trauma

poor sleep nausea numbness tinnitus heartburn sinus problems poor

libido

PLEASE CIRCLE IF YOU HAVE HAD – OR CURRENTLY HAVE - ANY OF THE FOLLOWING CONDITIONS:

arthritis asthma heart condition high blood pressure low blood pressure

hyperthyroid hypothyroid cancer diabetes chronic fatigue irritable bowel

fibromyalgia stroke aneurysm pneumonia epilepsy seizures

bleeding disorders chronic sinusitis skin condition joint dislocation

chicken pox digestive condition spinal injury head injury

osteoporosis hepatitis HIV bone fracture kidney disease urinary condition

DO YOU HAVE ANY OF THE FOLLOWING? Please Circle:

rods pins plates shunts implants transplants pace maker

OTHER THERAPY YOU ARE RECEIVING: Please checkmark:

Acupuncture ___ Therapist: _____
Massage Therapy ___ Therapist: _____
Chiropractor ___ Therapist: _____
Physiotherapy ___ Therapist: _____
Naturopath ___ Therapist: _____
Allopathic Dr./ Western Medical Treatment ___ Therapist: _____
Counseling ___ Therapist: _____
Other ___ Therapist: _____

PLEASE LIST ACTIVITIES, SPORTS, HOBBIES: _____
_____

CANCELLATION/LATE ARRIVAL POLICY:
Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24-hour notice of cancellation, or you will be charged for your scheduled appointment. A patient who arrives less than 30 minutes late for their appointment will receive an abbreviated treatment at the regular cost.
Please sign if you understand and agree. Signature_____