610-866-9087
3005 Brodhead Rd., Suite 100
Bethlehem, PA 18020

AUTHENTIC EASTERN HEALTH LLC
ACUPRESSURE CLIENT INFORMATION FORM

Date: _____ Name_____

Home Phone _____ Work _____Cell_____

When is the best time to call? _____ Best number to call? _____May we leave a message? _____

Address_____City/State_____Zip_____

E-Mail Address_____Birthday_____

Emergency Contact and Relationship _____Contact Phone_____

Occupation _____Referred by_____

MEDICAL INFORMATION

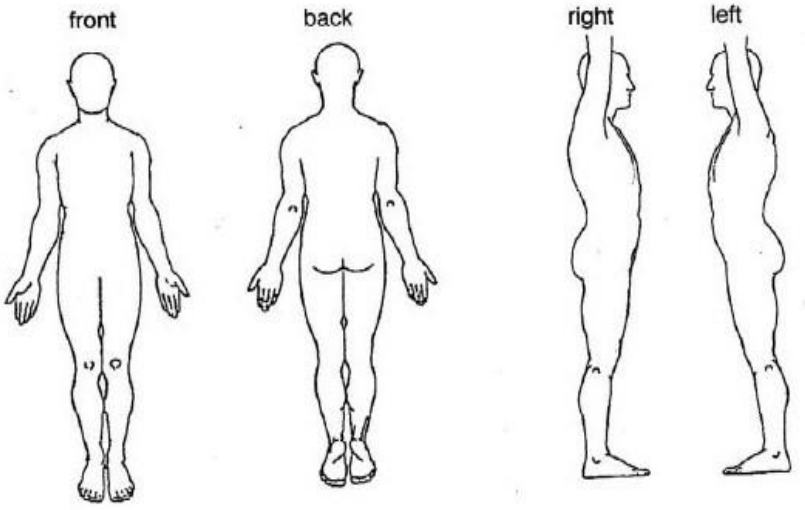
☐ Yes ☐ No Have you had a massage before? If yes, how recently? _____
☐ Yes ☐ No Do you frequently suffer from stress?
☐ Yes ☐ No Do you have diabetes?
☐ Yes ☐ No Do you experience frequent headaches?
☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Do you suffer from arthritis? Where: _____
☐ Yes ☐ No Are you wearing dentures?
☐ Yes ☐ No Do you have high blood pressure? If yes, do you take medication? _____
☐ Yes ☐ No Do you suffer from epilepsy or seizures?
☐ Yes ☐ No Do you suffer from joint swelling? Where?_____
☐ Yes ☐ No Do you have varicose veins?
☐ Yes ☐ No Do you have any contagious diseases?
☐ Yes ☐ No Do you have osteoporosis?
☐ Yes ☐ No Do you have any allergies?
☐ Yes ☐ No Do you have any skin conditions? If yes, what are they? _____
☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Have you had any broken bones in the past two years? Please list:_____
_____
☐ Yes ☐ No Have you been in an accident or suffered any injuries? If yes, what are they?
_____
☐ Yes ☐ No Do you have cardiac or circulatory problems?
☐ Yes ☐ No Do you suffer from neck or back pain?
☐ Yes ☐ No Do you have numbness or stabbing pains anywhere?
☐ Yes ☐ No Are you very sensitive to touch or pressure in any area?
☐ Yes ☐ No Have you ever had surgery? Please explain: _____
☐ Yes ☐ No Do you have, or have you ever had cancer?
☐ Yes ☐ No Do you have any other medical condition or are you taking any medications I should know about? _____
☐ Yes ☐ No Do you have tension or soreness (including sprains/strains) in a specific area? Please specify. _____
_____
☐ Yes ☐ No Do you exercise? Please list activities, frequency, and intensity: _____
_____
_____
☐ Yes ☐ No Do you have other concerns your massage therapist should be aware of? Please explain:
_____
_____

Over please

BODY MAP

Please complete the body map using the symbols below.

X – Areas I do NOT want massaged
O – Areas that need extra attention (pain, tension, or concern)



What are your goals of the therapy?

_____

RELEASE

Please read carefully and sign below.

I understand that the Acupressure and other oriental therapies (including Cupping, Herbs, Moxa, Guasha, Reflexology and Electro Acupressure) I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I also may request that the session be discontinued at any time, for any reason, and the therapist will honor that request.

I further understand that Acupressure and other therapies should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand the therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date _____

Therapist Signature: _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____Date_____

CONSENT FOR SERVICES

I, _____hereby attest and agree to the following:

1) I fully understand that Ping Jian Zhao is a lay natural health advisor who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.

2) I fully understand that Ping Jian Zhao is not a licensed physician and cannot diagnose diseases, prescribe drugs or recommend treatment for specific disease conditions.

3) I understand that all evaluations analysis performed by Ping Jian Zhao or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed physicians.

4) I understand that Ping Jian Zhao neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.

5) I certify that Ping Jian Zhao or her representatives have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Ping Jian Zhao or her representatives responsible for the consequences of my decisions.

6) I certify that I am here on this visit and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county or local government or private agency on a mission of investigation.

I have read and understand the foregoing and agree to the terms and conditions set therein. I also acknowledge that I am making a personal choice to receive educational sessions with Ping Jian Zhao, a Naturopathy Consultant. I understand that it is also my personal choice to act, or not, on any of the recommendations provided.

Date _____ Referred by: _____

Client Signature: _____

CANCELLATION and RETURN POLICY

Authentic Eastern Health, LLC requires 24-hour notice of cancellation prior to scheduled appointments. I hereby agree to pay $25 to Authentic Eastern Health L.L.C in the event I do not comply with this 24-hour cancellation policy.

If I am late for my appointment, my time may be cut short in order to keep other people on schedule.

Any return of herbal supplement products should be in the original sealed package and within 30 days.

Print Name: _____

Signature: _____ Date: _____