EverVital Holistic Acupressure Therapy

Confidential Client Intake Form – First Visit

1. Personal Information

- Full Name: _____
- Date of Birth: ____ / ____ / _____
- Gender: ☐ Female ☐ Male ☐ Other _____
- Phone Number: _____
- Email Address: _____
- Address: _____
- Emergency Contact Name & Phone**:**
  _____

2. Health & Safety Screening (To Avoid Risks)

Please check or fill in anything that applies to you. This helps us keep you safe.

- Do you have **high blood pressure**? ☐ Yes ☐ No
  If yes, is it ☐ Controlled by medication ☐ Not controlled
- Do you have **diabetes**? ☐ Yes ☐ No
  If yes, ☐ Type 1 ☐ Type 2 ☐ Not sure
- Do you have any **heart conditions** (past or current)?
  ☐ No ☐ Yes – please describe:
  _____
- Are you currently pregnant? ☐ Yes (____ weeks) ☐ No ☐ Not sure
- Do you have **osteoporosis, cancer, blood clots, seizures, or epilepsy**?

☐ No ☐ Yes – please explain:

_____

- Have you had **recent surgery** (past 1 year)?
  ☐ No ☐ Yes – what kind?

  _____
- Do you have any **implants or medical devices** (e.g., pacemaker, IUD, metal plates, etc.)?
  ☐ No ☐ Yes – please list: _____
- Are you taking **any medications** currently?
  ☐ No ☐ Yes – list name/purpose if known:

  _____
- Do you have **allergies** to oils, scents, latex, or anything else?
  ☐ No ☐ Yes – please list: _____
- Do you experience **fainting, dizziness, or sensitivity to pressure/touch**?
  ☐ No ☐ Yes – explain: _____

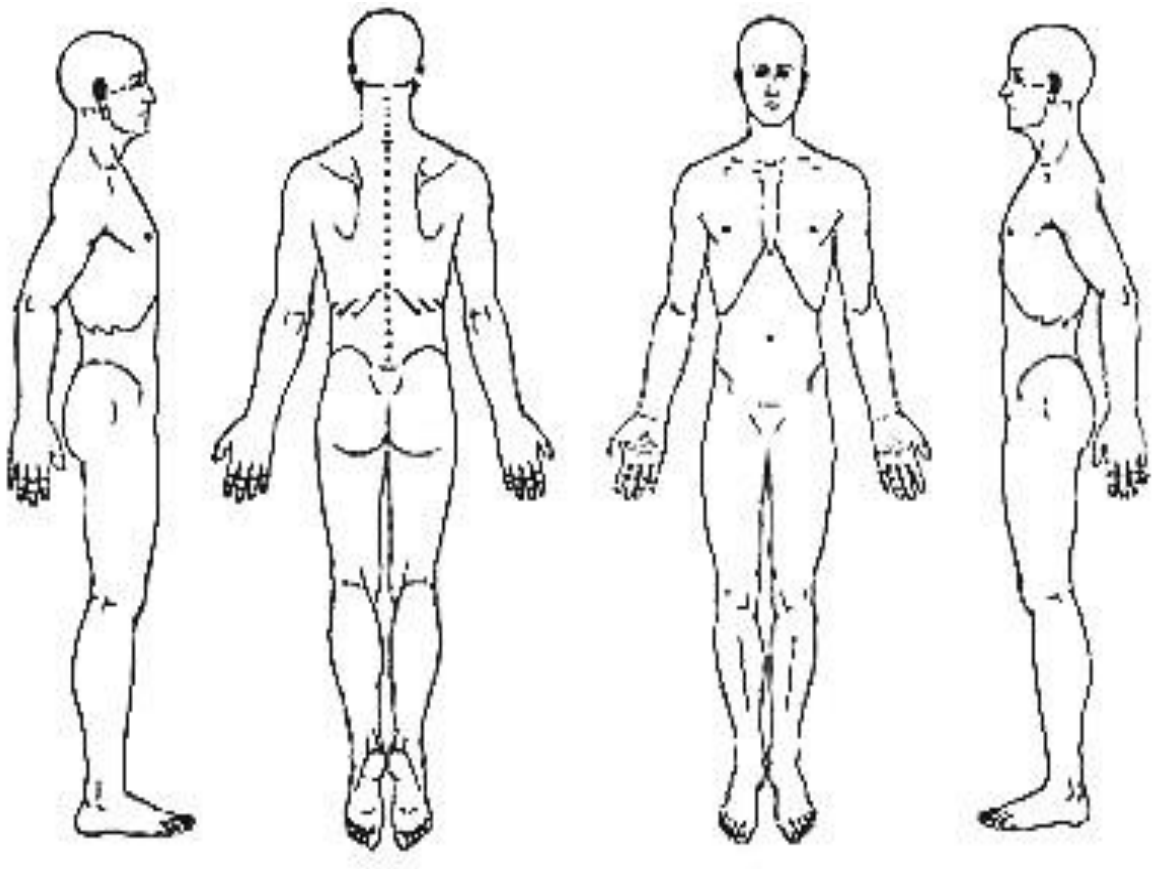
3. Main Concerns and Symptoms (So We Can Help You Best)

- What brings you in today?

  _____

  _____
- Where do you currently feel **pain, discomfort, or tightness**?
  ☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Upper Back ☐ Lower Back ☐ Hips
  ☐ Knees ☐ Feet ☐ Headaches ☐ Numbness ☐ Sciatica ☐ Other: _____
- How long have you had this issue?
  ☐ Days ☐ Weeks ☐ Months ☐ Years

- Please circle the painful or issues area on the picture:



- How would you describe your pain?
  ☐ Sharp ☐ Dull ☐ Throbbing ☐ Tingling ☐ Burning ☐ Shooting ☐ Other: _____
- What makes it feel **worse**?
  _____
- What makes it feel **better**?
  _____
- Do you have trouble with any of the following?
  ☐ Sleeping ☐ Digestion ☐ Stress ☐ Fatigue ☐ Anxiety ☐ Emotional balance
  ☐ Menstrual cycle ☐ Breathing ☐ Other:
  _____

- Have you ever tried:
  ☐ Massage ☐ Acupuncture ☐ Chiropractic ☐ Physical Therapy ☐ None

5: INFORMED CONSENT FOR ACUPRESSURE, CUPPING, AND GUA SHA

I understand that the following techniques may be used during my session, with my consent:

- Acupressure Therapy
- Cupping Therapy
- Gua Sha (Scraping Therapy)

These therapies are traditional, natural, and non-invasive. They are used to move qi and blood, relieve pain, and improve circulation.

I understand the following temporary reactions may occur:

- Bruising or red/purple marks from cupping or gua sha
- Soreness or tenderness in areas where pressure or scraping was applied
- Redness or slight swelling that fades over time
- Fatigue or emotional release after energy movement
- Skin sensitivity lasting 1–5 days

These are not injuries and usually fade within a few days to a week.

My Responsibilities:

- I will communicate openly during the session about any discomfort.

- I will inform my therapist of any medical issues, medications, or sensitivities.
- I understand this therapy is not a substitute for medical care, and no diagnosis or prescription will be provided.

Consent and Signature

[ ] I have read and understand the information above.
[ ] I give my voluntary consent to receive acupressure, cupping, and/or gua sha therapy.

[ ] **Herbal Liniment (Herb Wine) Consent：**

I understand that a traditional herbal liniment (herb wine) may be applied externally to my skin during my session as a massage enhancement to support circulation, relaxation, and muscle comfort.

I acknowledge that:

- The herbal liniment is for **external use only.**
- It contains alcohol and herbal ingredients.
- It is not a medical treatment and is not intended to diagnose, treat, cure, or prevent any disease.
- A skin sensitivity or patch test may be performed if needed.
- I may decline its use at any time during the session.

[ ] I give my voluntary consent to the topical application of herbal liniment (herb wine) during my session.

[ ] I understand that acupressure therapy is not a substitute for medical treatment.
[ ] I confirm that all information provided is accurate to the best of my knowledge.
[ ] I will inform the therapist of any changes to my health before

future sessions.
[ ] I give my consent to receive acupressure therapy.

Client Name (print):

_____
Signature:

_____

Date: ____ / ____ / _____