Gloria Provitola M.S. L.Ac.
Chi Nei Tsang/Massage Intake Form

DATE: _____

PATIENT INFORMATION

Name: _____

Gender: _____

Age: _____ Date of Birth: ___/___/_____ Social Security # _____-____-_____

Home Address: _____

Home Phone: _____Cell: Work Phone: _____

Email: _____

Emergency Contact: _____Relationship to Patient:_____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

I. EXPERIENCE WITH CHI NEI TSANG

• Have you received CNT treatment before? YES NO
• If yes, for what conditions and what was the outcome?

_____
_____

II. MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Name of medication, supplement or herb	Taking this for what condition or purpose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

III. DESCRIPTION OF MAJOR COMPLAINTS

In order of priority What are your complaints?	**Complaint 1**	**Complaint 2**	**Complaint 3**
How long have you had this condition?			
Was the onset gradual or sudden?			
Was there a significant event that lead to this condition? Please answer Yes or No.			
Have you seen a physician or other primary care provider for this complaint? If yes, what diagnosis did you receive?			
Please check other therapies you receive(d) to manage each complaint? Which is helping or has helped?	**Physical Therapy ___ Chiropractic___ Massage ___ Other _____**	**Physical Therapy ___ Chiropractic___ Massage ___ Other _____**	**Physical Therapy ___ Chiropractic___ Massage ___ Other _____**
Rate the intensity of the *PHYSICAL & EMOTIONAL DISCOMFORT* associated with each complaint (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)	**PHYSICAL _____ EMOTIONAL _____**	**PHYSICAL _____ EMOTIONAL _____**	**PHYSICAL _____ EMOTIONAL _____**
What relieves the symptoms of these complaints (e.g. heat, cold, pressure, movement, rest, etc)?	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**
What makes the symptoms of your complaint worse?	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**

I have answered these questions to the best of my knowledge.

Signature _____ Date:_____