New Patient Intake, History & Waiver

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General Information

Last Name	First Name	Middle Name	Date of Birth (month/day/year)	Age	Gender ☐ Male ☐ Female

Residential Address

Home Address	City	Province	Postal Code	Cell Phone Number ( )

Emergency Contact

Full Name	Relationship	Cell Phone Number ( )

Health History

Height (Ft/Inches)	Weight (Pounds)	I have a Family Doctor ☐ Yes ☐ No	Approx. Date of Last Physical	History of Spiritual Diseases? (magic/possession) ☐ Yes ☐ No Describe:		
Smoker? ☐ Yes ☐ No How long?	Diabetic? ☐ Yes ☐ No How long?	Cancer? ☐ Yes ☐ No Describe:	Contagious Disease? ☐ Yes ☐ No Describe::	Recent Accident? ☐ Yes ☐ No Describe:	Heart Conditions? ☐ Yes ☐ No Please Explain	Headaches? ☐ Yes ☐ No How Often?
High / Low Blood Pressure: ☐ Yes ☐ No	Varicose Veins ☐ Yes ☐ No	Surgery in the past year? ☐ Yes ☐ No Describe:	Allergies? ☐ Yes ☐ No Describe:	Hepatitis? ☐ Yes ☐ No Type:	Pregnant? (Women) ☐ Yes ☐ No Due Date:	Date of Last Menstruation (Women):
Occupation:		Please List any History of Major Illnesses in your Family:		Please List any Medications you are taking, including Vitamins/Supplements:		

Hijamah History

How did you find us?	Is this your first time? ☐ Yes ☐ No	Approx. Date of last Hijamah:	Where on your body was it done?	By whom and in what city/country?	If today is a success can you provide a testimonial? ☐ Yes ☐ No thanks

Rate the Following Lifestyle Questions from 1 to 10:

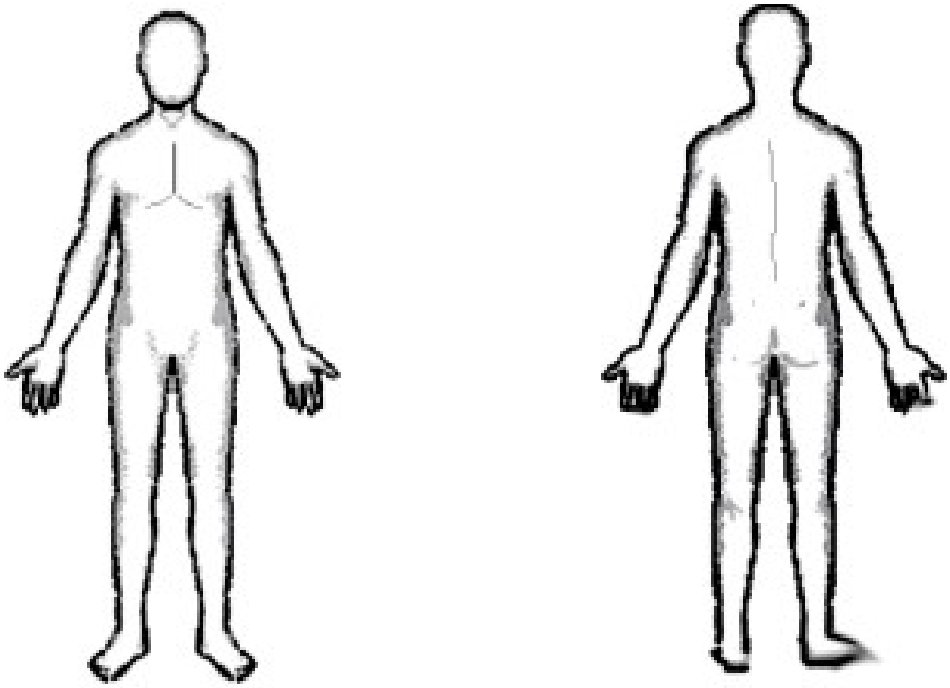
(1=Needs Improvement, 10=Very Good)

Sleep	Focus	Morning Energy	Afternoon Energy	Productivity	Motivation	Memory	Healthy Eating	Level of Stress	Digestion	Relation-ships	Physically Active

Please Describe Your Goals for Hijamah:

Primary:	**Secondary**:
Type of Hijamah Desired (please mark all that apply): ☐ Wet Hijamah (Blood Cupping) ☐ Dry Hijamah (no blood) ☐ Massage Cupping ☐ Cupping Facial ☐ I'll let my therapist suggest	

Please Indicate Any Areas of Pain:



Treatment Plan (Shaded Area for Office Use Only):

Session #1:	**Session #2:**	**Session #3:**	**Session #4:**
Initial Treatment Plan and Frequency:		**Long Term Maintenance Plan:** ☐ Every 6 months ☐ Every 3 Months ☐ Every Other Month ☐ Other:	
Suggested Supplements / Lifestyle Improvements:			

HijamahWorks Client Waiver and Release Form

As a patient and practitioner relationship it is very important you have disclosed all of your health background information to ensure safety and success of the procedure. Please review the following and sign below before your treatment:

- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I understand that the medical information recorded in this form is for informational/therapeutic use only and is strictly confidential.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- Information has been provided to me about Cupping Therapy. I understand the potential effects and after care procedures.

It has been explained to me that there is the possibility of discolorations of my skin that can occur for the release and clearing of stagnant fluids and toxins from my body.

- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to clear away from my circulatory systems.
- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relations to my after-care activities.

I understand that Hijamah Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn or when I'm hungry or thirsty.

- I understand that I should avoid exposure to extreme cold, wet, and or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to sure extremes can produce undesired effects and I should avoid such situations.
- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.
- I understand that I should avoid sexual activity/marital relations for 24 hours.

I have fully disclosed all health factors to my therapist, including those not mentioned on my health history intake form, to avoid any complications.

- It has been explained to me that there are contraindications for Cupping Therapy. The following list of conditions can be affected by Hijamah Cupping Therapy and based on the Therapist's discretion, according to the illness, conditions and stress levels that the Client presents with after a treatment:
- Diabetes, Epilepsy, Severe Edema, Cancer, Current Fractures, Active shingles, Cuts/abrasions, Recent sprains/strains, Skin Disease/ disorders, Undiagnosed lumps on body Heart Condition, High/Low Blood Pressure, Thrombosis/Embolism, Nerve dysfunction, Varicose Veins, Lacerations/Ulcers, Ingrown toenails, Gout, Early stages of Labor, Contagious diseases, Post-operation of an organ transplant, Recent Injuries/surgery, Recent hemorrhage, Sunburn/windburn, Warts/skin tags, Moles, Bone fractures, Memory Problems, Mood, Bleeding disorders
- I understand that I must consult with my healthcare provider if I currently have or develop any of the above mentioned conditions, before I can commence with anybody and energy work.

I understand that the Practitioner may combine therapies and tailor-make a treatment package for me which could include any or all of Dry/Massage/Wet Hijamah. The Practitioner has explained the procedures for all of these treatments.

- I understand that there will be usage of a sterile surgical blade and blood work during the wet hijamah procedure.
- I understand this may require the removal of my shirt and/or pant physical contact between myself and my practitioner I give permission to the Practitioner to use a small, surgical, incision blade on my body in order to scratch the surface of the skin and draw a small amount of toxic blood according to her professional discretion. I understand that results may not be immediate after each therapy.

I, _____ (Print Name), agree that I have read, understand and will follow all of the information stated above, allow hijamah to be performed on myself, and will not hold the practitioner responsible. On this date _____.

Signature of Client	Signature of Practitioner: