Patient Acceptance Form

Personal Information

Name_____**Last name**_____

Address_____

Tel._____ **Mobile.**_____

E.Mail_____

Date of birth_____ **ID number** _____

Health condition

1	Do you currently have any pain? (Please mark the place in the form provided)	Yes/No
2	Do you now have an illness or health disorder - physical or mental?	Yes/No
3	Are you taking medication?	Yes/No
4	Are you in medical care?	Yes/No
5	Have you had any surgery in the last six months?	Yes/No
6	Has your body been damaged by an accident, illness or any other reason in the past?	Yes/No
7	Do you suffer from any allergies (to any oils)?	Yes/No
8	Have you had a stroke in the past?	Yes/No
9	Have you had cancer in the past?	Yes/No
10	Is there anything you are not asked about and would like to add?	Yes/No
11	Are you pregnant? month:	Yes/No
12	Are you breastfeeding?	Yes/No
13	Are you menstruating?	Yes/No

If you've answered yes to any of the questions, please fill out a medical questionnaire.

Declaration

I confirm that I am aware that the treatment requested by me is not a substitute for any treatment in conventional medicine and / or any consultation with a conventional doctor, and that I do not intend to discontinue any medication without consulting a doctor.
I declare that I am aware that the treatment is carried out as part of the therapist's apprenticeship and I waive my right to sue the therapist in the future in connection with this treatment.
I confirm that my answers to all the questions are complete and honest and that I did not lack any information.

_____ Date

_____ Signature

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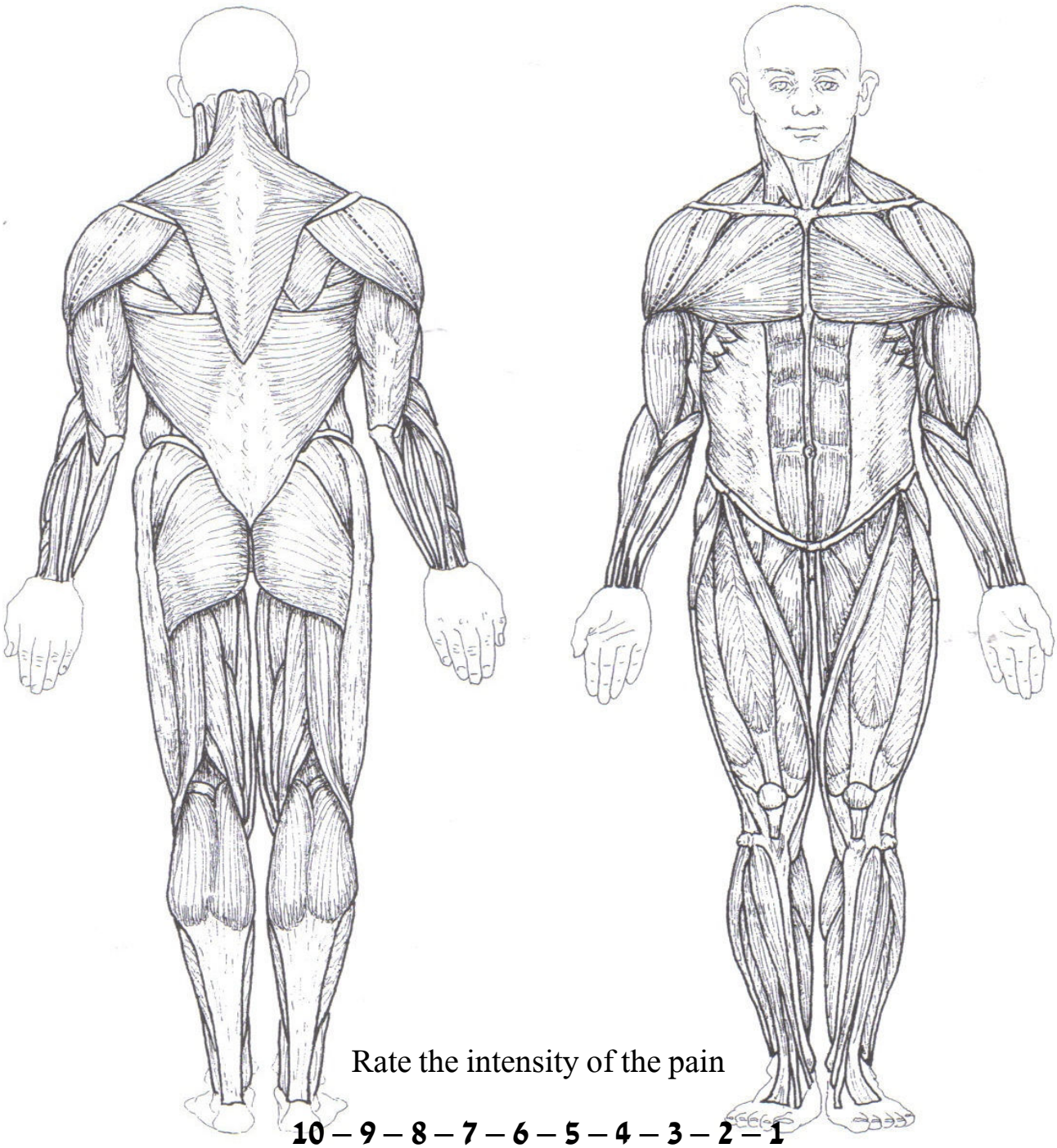
לוטוס
אמנות הריפוי והעיסוי

Name _____ Date_____

Mark the location of the pain



Rate the intensity of the pain

10 – 9 – 8 – 7 – 6 – 5 – 4 – 3 – 2 – 1

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Health questionnaire

The patient's information appearing in this questionnaire is confidential. The information in this questionnaire will be used by the therapist solely in order to best treat the patient and in a way that supports his / her needs and goals.

Part C - Details of the state of health

If you've answered one of the questions in the affirmative, please specify.

Details:_____

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Declaration

I confirm that I am aware that the treatment requested by me is not a substitute for any treatment in conventional medicine and / or any consultation with a conventional doctor, and that I do not intend to discontinue any drug treatment without consulting a doctor.
I confirm that my answers to all the questions are complete and honest and that I did not lack any information.

_____ _____

Date Signature

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Documentation of treatment

treatment duration: _____

date: _____

Patient's bservation/Remark:

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The therapist bservation/Remark:

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Patient's bservation/Remark:

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The therapist bservation/Remark:

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