Alif2Yaa Health Services

Patient Intake Form

Name:

Address:

Contact Number: Email:

Date of Birth: Age:

Emergency Contact and their relationship to you:

Were you referred by anyone? If so, by whom so we may thank them:

Have you ever received Cupping Therapy/Hijama before? (If yes, how was it?)

What (specifically) would you like to treat using Cupping Therapy?

Would you like me to focus on or stay away from any specific area?

If today's session is a success would you be able to provide a short testimonial for our website? Y / N

Family History (Major illness, operations):

Please list any recent illnesses, hospitalizations, surgeries or accidents you have experienced:

Are you currently taking any medications or supplements (prescription or non-prescription): Y /N If yes, names of medications, doses and how often taken:

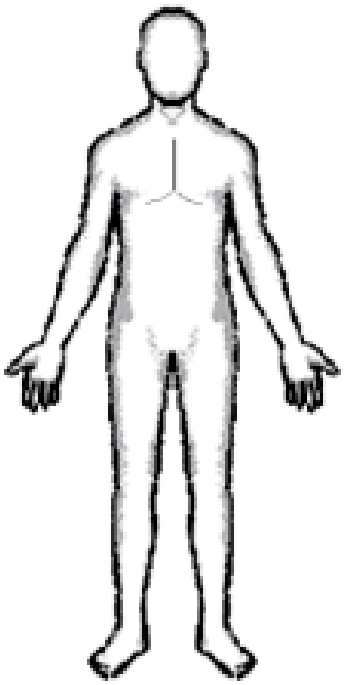
Health History

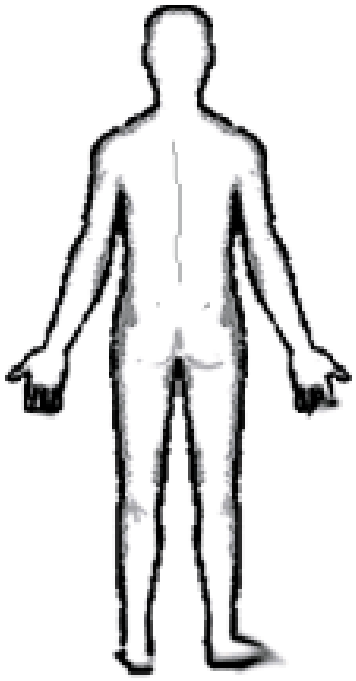
Do you have or are you any of the following (Please circle Y=Yes or N=No):

Smoker? Y / N
Pregnant? Y / N Wks:
Contagious Disease? Y/N
High/Low Blood Pressure? Y/N
Heart Conditions? Y/ N
Allergies? Y / N List:

Diabetic? Y /N
Varicose Veins? Y / N
Cancer? Y / N
Frequent Headaches? Y/N
Surgery Incisions? Y/N
(Women) Date of last Menstruation Cycle:

Circle areas you are currently experiencing Pain:





I attest that the above is true and accurate to the best of my knowledge.

Signature: Date:

Client Release Form

- 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. If I choose to experience these therapies during treatments, I understand the potential effects and after care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. 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 is the possibility of discolorations that can occur for the release and clearing of stagnation 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 Cupping 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.

Contraindications: The following list of conditions can be affected by Hijama Cupping Therapy and based on the Therapist's discretion, according to the illness, conditions and stress levels that the Client presents with.

- 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 the medical information recorded in this form is for informational/therapeutic use only and is strictly confidential. I understand that I must consult with my healthcare provider if I currently have or develop any of the abovementioned 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 the following treatments: Hijama (Dry/Massage/Wet). The Practitioner has explained the procedures for all of these treatments. I understand that there will be usage of a surgical blade and blood work during the WET CUPPING procedure.
- 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 _____. agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

Date: Signature of Client:

Signature of Practitioner: