Chi Nei Tsang
Initial Treatment

Name:________________________ Date:__________

Address:______________________ Height:__________

______________________________ Weight:__________

Phone: H:____________________ Birthdate:__________

W:____________________

Reason for receiving massage:

Major health concerns:

Currently being treated by a physician? NO

YES, by whom?

for what?

Taking any medications?
supplements?

PULSES: R L

1

2

3

TONGUE:

TX notes:

Feedback: