Shiatsu Intake Form

DATE

PURCHASED PRODUCT/SERVICE

FIRST NAME

LAST NAME

Date of Birth

Age

Height

Weight

Home Address

City

State

ZIP

Home Phone

Cell Phone

Email

Would you like to be on our mailing list?

- ◯ Choice 1
- ◯ Choice 2

Name of Emergency Contact

Contact Phone Number

How did you hear about us?

Search Engine

- ☐ Yellow Pages
- ☐ Google Engine
- ☐ Referral
- ☐ Other

Why did you choose to have a Zen Shiatsu Therapy?

Did you have Shiatsu before?

When was your last Shiatsu session?

How many session have you had?

Shiatsu Practitioners look to the roots of imbalance and which energetic system is showing the most symptoms. Therefore, your careful and thoughtful answers will provide you with a more effective session. Even if you are just looking for a pleasant bodywork session and not concerned with any particular issues, please take the time to complete all relevant information. Please ask if you have any questions.

MEDICAL HISTORY

Are you currently under the care of a Medical Doctor or other Alternative Health Care Provider? (Y / N)

Provider Name

Phone Number

Type of Treatment

Please list all medications you are currently taking:

Type

Reason

Dosage & duration you've been taking

- ☐ Allergies, sensitivity
- ☐ Asthma
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Abnormal skin conditions
- ☐ Elimination problems
- ☐ Hemorrhoids
- ☐ Crohn's disease
- ☐ Digestive complaints
- ☐ Food cravings (specify)
- ☐ Feeling of heaviness in body
- ☐ Mental fatigue
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Heart problems (specify)
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Insomnia, difficulty falling asleep
- ☐ Dream disturbed sleep
- ☐ Anxiety
- ☐ Distention in lower abdomen

- [ ] Low back and/or knee pain
- [ ] Osteoporosis
- [ ] Urinary problems and/ or infections
- [ ] Phobias/ Fears
- [ ] Nervous problems
- [ ] Ear problems
- [ ] Wake up many times at night
- [ ] Sexual/reproductive dysfunction
- [ ] Swollen lymphatic glands
- [ ] Hypersensitivity
- [ ] Rashes/ hives
- [ ] Nervous in social situations
- [ ] Swelling or chilling of extremities
- [ ] Circulatory problems
- [ ] High Blood Pressure
- [ ] Dizziness
- [ ] Anger /irritability
- [ ] Stiff joints
- [ ] Jaundice
- [ ] Sore eyes
- [ ] Brittle nails
- [ ] Wake up early then fall asleep again

- [ ] Anemia
- [ ] Arthritis (specify)
- [ ] Candida
- [ ] Cancer
- [ ] Chronic fatigue syndrome
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fibromyalgia
- [ ] Headaches, migraines
- [ ] Mental health issue
- [ ] MS
- [ ] Sprains/strains (specify)
- [ ] Tendonitis (specify)
- [ ] Recent injuries(specify)

Females :

- [ ] Menstrual Problems (specify eg. cramps)
- [ ] Menopause

Current Condition

Please rate the following with a circle. 0 = none 10 = the most/highest

	0	1	2	3	4	5	6	7	8	9	10
Pain	○	○	○	○	○	○	○	○	○	○	○
Energy	○	○	○	○	○	○	○	○	○	○	○
Stress	○	○	○	○	○	○	○	○	○	○	○

Main problem(s) you would like help with today

How long ago did the problem(s) begin? – be specific

To what extent does the problem(s) interfere with your daily activities?

Have you ever been given a diagnosis for this problem(s)? If so, what diagnosis and by whom?

What kind of treatments have you tried, what has helped?

Five Element Checklist
Please mark as follows: (S) = Sometimes Experience (O) = Often Experience

ST/SP

- ☐ Appetite – too high, too low
- ☐ Tiredness
- ☐ Loose stools
- ☐ Constipation
- ☐ Chronic Sinus infections
- ☐ Indigestion/heartburn/reflux
- ☐ Bloating/gas after eating
- ☐ Belching, Vomiting, nausea, pain
- ☐ Mental fatigue – foggy
- ☐ Weak limbs – lack flexibility
- ☐ Undigested food in stool
- ☐ A feeling of retention of food in the stomach
- ☐ Bleeding gums
- ☐ Bruise easily
- ☐ Cold Limbs
- ☐ Tendency to become obsessive
- ☐ Worry too much

LU/LI

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Weak voice
- ☐ Dry throat, hoarseness, dry cough
- ☐ Daytime sweating
- ☐ Nighttime sweating
- ☐ Skin problems, eczema, and psoriasis
- ☐ Toothaches

HT/SI

- [ ] Insomnia, difficulty sleeping
- [ ] Heart palpations
- [ ] Anxiety
- [ ] Dizziness
- [ ] Insomnia
- [ ] Dream disturbed sleep
- [ ] Easily startled
- [ ] Blood clots
- [ ] Mental confusion
- [ ] Cold limbs
- [ ] Feeling of heaviness in chest
- [ ] Pain radiating down left arm
- [ ] Uncontrollable laughter or crying
- [ ] Spontaneous sweating

LV/GB

- [ ] Pain – general body pain
- [ ] Sighing (do you notice yourself sighing)?
- [ ] Depression
- [ ] Numbness in extremities
- [ ] Tics or tremors
- [ ] Dizziness
- [ ] Anemia
- [ ] Eyes – blurred, floaters, dry, red?
- [ ] Dry skin/hair – brittle nails
- [ ] Stiff neck/ joints – chronic
- [ ] PMS – any related issues
- [ ] Headaches
- [ ] Diarrhea
- [ ] Flashes of anger
- [ ] Bitter taste in mouth

TH/PC

- [ ] Swollen lymphatic glands
- [ ] Nervous in social situation
- [ ] Tonsillitis
- [ ] Allergies
- [ ] High Blood pressure
- [ ] Low Blood pressure
- [ ] Sensitive skin
- [ ] Rashes
- [ ] Hives

KI/UB

- [ ] Asthma
- [ ] Cold limbs
- [ ] Excess urination
- [ ] History of Urinary tract infections
- [ ] Incontinence
- [ ] Dizziness
- [ ] Tinnitus – ringing in ear
- [ ] Night sweats
- [ ] Sore or weak back
- [ ] Knee – sore or weak
- [ ] Edema
- [ ] Aversion to cold
- [ ] Weak bones, teeth
- [ ] Low Libido/ Sexual dysfunction

Are you a morning, midday, afternoon, early evening or night person?

	Spring	Summer	Late summer	Fall	Winter
Which season do you love the most?	○	○	○	○	○
Which season do you dread?	○	○	○	○	○

What are your favorite colors?

Which colors are you avoiding now?

	Sour	Bitter	Sweet	Spicy	Salty
What is your favorite taste?	○	○	○	○	○

Have you craved any of these tastes this week? If so, which?

INFORMED CONSENT TO SHIATSU THERAPY

It is my choice to receive shiatsu therapy. I realize that the treatment is being given for the well-being of my body, emotions and mind. This includes stress reduction, relief from muscular tension, spasm/pain, and improving circulation. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand and am informed that in the practice of shiatsu there are some possible physical, emotional and mental side effects that may occur. I do not expect the therapist to be able to anticipate and explain all risks and complications. I rely on the therapist to exercise his best judgment during the course of the procedure, which he feels at the time, based upon the facts then known, is in my best interest. I further understand that results are not guaranteed.

I understand that Shiatsu therapists do not diagnose illness, disease, or any physical or mental disorders, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that shiatsu is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update my shiatsu therapist of any changes in my health status.

I have read the above consent. I have had an opportunity to ask questions about its content, and by signing below, I agree to the included procedures. I intend this consent form to cover the entire course of my treatment plan.

TO BE COMPLETED BY PATIENT:

_____

Print client's name

Signature of Client (or parent/guardian)

Date signed