

Confidential Health Inventory

First time receiving Shiatsu: Yes/No

Today's Date: _____ Children: Yes/No Employed: FT/PT/School/Retired/Unemployed/Other (circle)

Full Name: _____ Age: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Mailing address if different: _____

Preferred Phone #: _____ E-Mail address: _____

Occupation: _____ Relationship status: Single/Married/Divorced/Widowed/Partnered/Caregiver (circle)

In case of Emergency contact: _____ Phone #: _____

Main concern/reason for seeking Shiatsu: _____

This condition has existed since _____ and is improved/aggravated by _____

My overall health is: ___ Excellent ___ Good ___ Fair ___ Poor (and) ___ Improving ___ Declining

Allergies (food, chemical, seasonal, drugs, animal, etc.): _____

Accidents, traumas, or injuries: _____

Are you under the care of any other physician or health care provider? Yes/No _____ (type)

Please describe your daily food intake (types of food, skipped meals, cravings, etc.): _____

Please list all prescription and non-prescription drugs or supplements/herbs you are using: _____

Please describe your use of antibiotics, laxatives, tobacco, and caffeine (if any): _____

Do you have any known nutritional deficiencies: _____

Describe your daily intake of water, juice, soda, tea, coffee, etc.: _____

Describe your exercise habits: _____

Digestion: ___ Indigestion ___ Bloating ___ Heartburn ___ Nausea ___ Vomiting ___ Full feeling/distention ___ Belching
___ Pain or cramps ___ Gas ___ Bitter taste in mouth ___ Normal ___ Other: _____

Stools: ___ Formed ___ Unformed ___ Hard ___ Average ___ Soft ___ Runny ___ Strained _____ Freq. per day/week

Energy level: ___ Up and down ___ Low ___ Normal ___ Excess ___ Low after eating ___ Low in afternoon

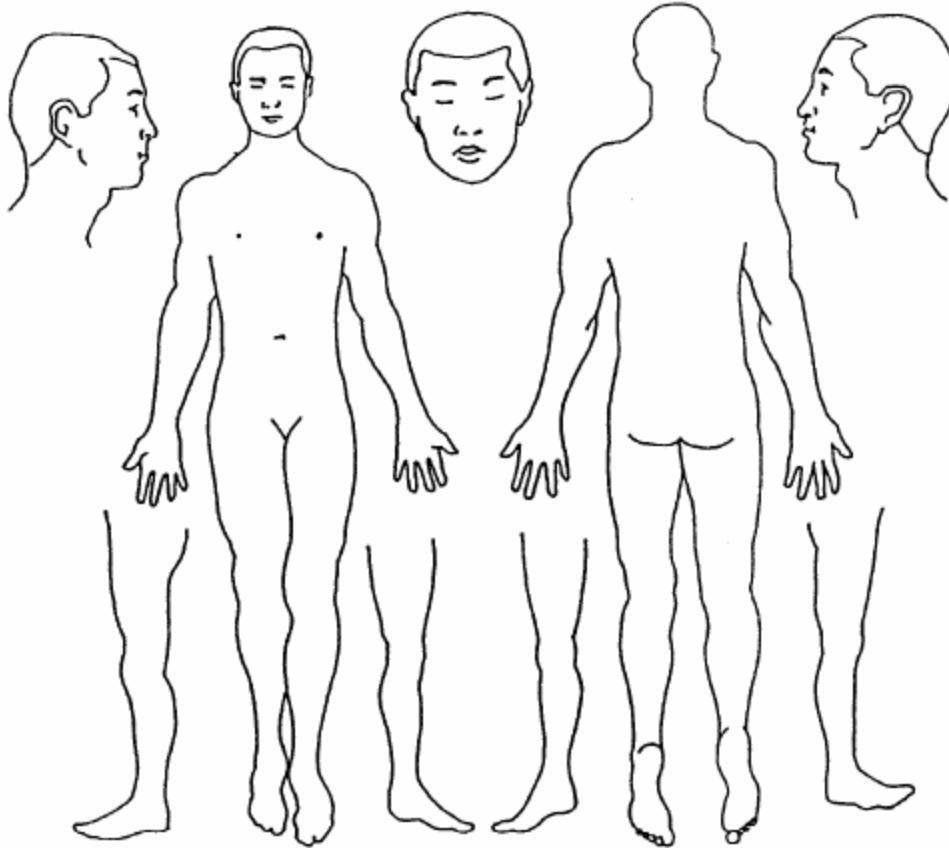
Please list all current health conditions (such as, but not limited to: asthma, palpitations, frequent urination, acne, frequent headaches, diabetes, varicose veins, STDs, arthritis, poor sleep, frequent colds/flu, contagious diseases, chronic fatigue):

(If applicable) Menstrual cycle: ___ Irregular painful ___ Heavy flow ___ Scanty flow ___ Dark color ___ Light color
___ Clotting ___ Water retention ___ Bloating ___ Breast lumps ___ Spotting between periods ___ Tightness in chest
___ Lump in throat feeling ___ Backache _____ Length of cycle ___ Menopausal ___ Post-menopausal

Vaginal discharges: ___ Yellow ___ Thick ___ Bad odor ___ White ___ Clear ___ Other _____

Are you pregnant now? Yes/No Might you be pregnant? Yes/No Are you trying to conceive? Yes/No

Do you have pain? Please describe and mark on the diagram below: _____



Signature: _____ Date: _____

Disclaimer: By signing above, I agree that I understand the Shiatsu therapist is not a doctor and cannot prescribe medications or treat/diagnose any mental or physical illness. I understand that Shiatsu therapists are not qualified to perform spinal or skeletal adjustments and that Shiatsu is primarily for relaxation and relief of body tension. Some symptoms may contraindicate Shiatsu treatment and may require approval from my primary care provider prior to services. If I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure or technique can be adjusted to my level of comfort. I further understand that Shiatsu therapy should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that the therapist does not discriminate on the basis of race, religion, sexual orientation, gender, or age. I understand illicit or sexual remarks or advances are inappropriate and will not come from the therapist or from me and will result in the immediate termination of the session, and I will be liable for the payment of the scheduled appointment if I behave in this inappropriate manner. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so. Because Shiatsu therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly.

The client intake form is for practitioner use only. If you are uncomfortable completing any part of the form, please leave that question blank and we can review the necessity of that information together during your first appointment. Receipts, documentation, and other pertinent client information will be released upon client request to assist you if you are filing a health insurance reimbursement claim.