

# SHIATSU INTAKE FORM

|                                |   |
|--------------------------------|---|
| <b>CONTACT INFORMATION</b>     | Today's Date _____                              |
| Name: _____                    | Date of Birth: _____                            |
| Address: _____                 |   |
| City: _____                    | State: _____ Zip: _____                         |
| Primary Phone #: (h/w/c) _____ | Secondary Phone #: (h/w/c) _____                |
| Email: _____                   | Would you like to be on the mailing list? _____ |
| Emergency Contact: _____       | Relation to you: _____                          |
| Phone #: _____                 |   |

How did you hear about Zen Shiatsu?

Have you had Shiatsu or other types of bodywork before?

What are your goals for this treatment?

**PRESENT SYMPTOMS:**

What is your major complaint or condition you want to work with?

On a scale of 1-10, 1=low and 10=high, indicate the level of discomfort this condition has given you.  
The worst it has felt: \_\_\_\_\_ Currently? \_\_\_\_\_

What makes the condition worse?

What eases the discomfort?

Have you seen other practitioners, doctors, or therapists regarding this condition?

# HEALTH HISTORY

Please indicate C=Current, P=Past Year, H=History prior to the past year  
Level of Discomfort – M=Mild, O=Occasional, L=Limiting, S=Severe

## Musculo-skeletal

- Headaches
- Joint stiffness/swelling
- Arthritis
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Jaw pain/TMJ
- Tendonitis
- Sciatica
- Osteoporosis
- Scoliosis
- Other \_\_\_\_\_

## Circulatory/Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High/Low blood pressure
- Nose Bleeds
- Lymphedema
- Other \_\_\_\_\_

## Skin

- Rashes
- Allergies
- Athlete's foot
- Warts
- Moles
- Acne
- Other \_\_\_\_\_

## Digestive

- Indigestion
- Intestinal gas/bloating
- Constipation
- Diarrhea
- Irritable bowel syndrome
- Colitis
- Crohn's disease
- Taste in Mouth \_\_\_\_\_
- Other \_\_\_\_\_

## Nervous System

- Numbness/tingling
- Twitching of face
- Chronic Fatigue Syndrome
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Cerebral palsy
- Epilepsy
- Fibromyalgia
- Multiple Sclerosis
- Muscular Dystrophy

## Reproductive System

- Currently Pregnant?
- PMS
- Menopause
- Endometriosis
- Fertility concerns
- Other \_\_\_\_\_

## Other

- Diabetes
- Cancer \_\_\_\_\_
- Surgeries \_\_\_\_\_
- Severe injuries \_\_\_\_\_
- Other illnesses \_\_\_\_\_
- Hearing impaired
- Visually impaired
- Hair Loss
- Urinary Tract Infection
- Yeast Infection
- Eating disorder
- Loss of appetite
- Weight Loss/Weight Gain
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Other \_\_\_\_\_

## Habitual Consumptions: Frequency?

- Cigarettes \_\_\_\_\_
- Caffeine \_\_\_\_\_
- Alcohol \_\_\_\_\_
- Other \_\_\_\_\_



Notes:

**LIFESTYLE**

Exercise: \_\_\_\_\_

Dietary Considerations: Vegetarian Vegan Omnivore Other \_\_\_\_\_

Food and Nourishment: What do you typically eat and at what time for each meal?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Medications taken within last two months: \_\_\_\_\_

Supplements taken within last two months: (herbs, vitamins, etc.) \_\_\_\_\_

**QUALITY OF LIFE**

Please describe your sleeping patterns. What time do you fall asleep? Are you awake in the night? What time do you wake up? What is the quality of your sleep?

Please describe your energy levels throughout the day. Are you aware of any patterns of when you have more or less energy during the day?

Please rate the following on a scale of 0-10 of emotions you experience on a daily basis.

\_\_Sadness, Grief    \_\_Worry, Sympathy    \_\_Joy    \_\_Fear    \_\_Anger

How would you rate the quality of relationships in your life right now (Partner, children, friends, family, etc.)?

Strong      Supportive      Good      Demanding      Absent      Strained

What colors do you tend to be drawn towards? \_\_\_\_\_

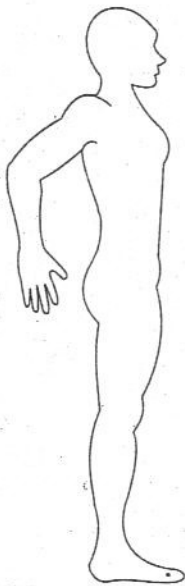
If you could change one thing in your life right now, what would it be? \_\_\_\_\_

Notes:

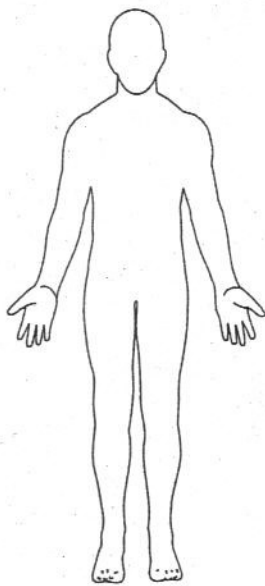
## MAP OF PHYSICAL CONDITION

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.

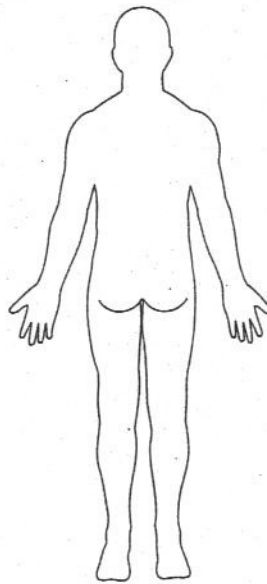
|            |   |  |
|------------|---|--|
| <b>Key</b> | ○ | Circle areas where pain exists                         |
|            | ⊙ | Circle areas with small dots where extreme pain exists |
|            | × | Put an "X" over stiff areas                            |
|            | ⋈ | Draw squiggly lines over areas of numbness or tingling |
|            | ⦚ | Mark scars, bruises or wounds                          |



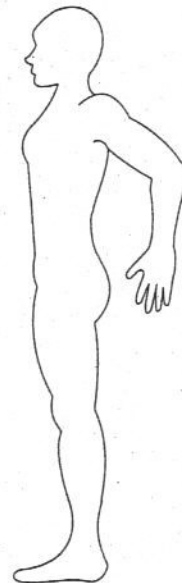
Right



Front



Back



Left