Intake Form

Therapist:________________________

Date:________________________________

Please take a few minutes to fill out the following health questionnaire.

All information is strictly confidential and will not be released without written consent.

General Information

Last Name:____________________________ First Name:_____________________________

Address:____

Telephone: (H):___________ (B):____________ E-mail:________________________

Date of Birth: _______________ Occupation: ___________________________________

Please describe briefly the condition(s) requiring attention. Please include duration of condition:____

Have you had shiatsu before? ☐ yes ☐ no

Would you like to be on our mailing list? ☐ yes ☐ no

Presently seeing: ☐ MD ☐ naturopath ☐ chiropractor ☐physiotherapist ☐ psychotherapist Other:_______

Medical Status

General Health: ☐ excellent ☐ good ☐ fair ☐ poor

Energy Level: ☐ excellent ☐ good ☐ fair ☐ poor

Medications: ☐ vitamins ☐ herbs ☐ homeopathy Other:_______

☐ prescriptions (please specify drug and for what condition prescribed)

____

Exercise: ☐ frequent ☐ often ☐ seldom ☐ occasional ☐ never

Allergies (please describe): ____

Surgery (please provide dates and details): ____

____

Fractures/dislocations/sprains (please provide dates and details: _______________________

____

Medical Status Continued

Childhood diseases: ☐ measles ☐ chickenpox Other:____________________

Use of tobacco: ☐ frequent ☐ occasional ☐ seldom ☐ never

Use of alcohol: ☐ frequent ☐ occasional ☐ seldom ☐ never

Use of caffeine: ☐ frequent ☐ occasional ☐ seldom ☐ never

Mood Alterants ☐ frequent ☐ occasional ☐ seldom ☐ never

Have you ever had any of the following conditions?

☐ heart trouble ☐ arthritis ☐ rheumatism ☐ kidney problems

☐ asthma ☐ colitis ☐ chronic fatigue ☐ skin disorders

☐ depression ☐ epilepsy ☐ diabetes ☐ cancer

Please provide details (past, present, duration, etc.): ________________________________

____

Do you bruise easily? ☐ yes ☐ no

General Physical

Skin and hair: ☐ rashes ☐ eczema ☐ itching

☐ dandruff ☐ pimples ☐ hives

☐ ulcerations ☐ loss of hair Other:____________

Body pains: ☐ muscles ☐ joints ☐ back ☐ neck

☐ shoulders Other:______________ how long?________________

Type of Pain: ☐ sharp ☐ persistent ☐ dull ache ☐ throbbing

Frequency: ☐ frequent ☐ often ☐ occasional ☐ seldom

Head: ☐ dizziness ☐ fainting ☐ sinus trouble

☐ eye problems ☐ hearing problems ☐ light-headedness

☐ headaches (please describe):________________________________

Chest: ☐ chest pain ☐ palpitations ☐ wheezing

☐shortness of breath ☐ chronic cough ☐ congestion

☐ mucous colour: _______________ amount: ______________

General Physical Continued

Appetite: ☐ hearty ☐ lack of appetite

☐ cravings (please describe):________________________________

Digestion: ☐ bloating ☐ heartburn ☐ flatulence

☐ nausea ☐ cramps ☐ belching

Bowel movements: Frequency:______________________________ ☐ blood in stool

☐ haemorrhoids ☐ constipation ☐ diarrhea

Urination: ☐ frequent ☐ painful ☐ bloody ☐ in the night

☐ inability to empty bladder ☐ inability to hold bladder

Stress: ☐ family ☐ work ☐ financial

☐ personal ☐ environmental Other:___________

For Women Only:

Menstruation: ☐ regular ☐ irregular colour:__________________________

Length of Period:_______________________ Amount of flow:_______________________

☐ pain/cramping (please indicate where):____

☐ unusual vaginal discharge (please describe):______________________________________

Are you pregnant? ☐ yes ☐ no

Signature:____ Date:__________________