Confidental Intake Form

Name______________________________Date of Birth______________Occupation _______________________________
What else do you do? ____
What do you wish to address with this treatment ? ____
When did it begin?_________________ Describe symptoms or patterns____
____
Are you currently seeing a doctor, or undergoing any other therapies? ____
When you get sick, what do you get and how often? ____
have you ever had surgery? (what/when) ____
accidents/injuries: unconscious ______________________ broken bones (what/when) ____________________________
other ____
Are you a trauma survivor ? Y / N

please circle where appropriate. add any details you wish, they always help.

sleep pattern regular / not insomnia not enough/too much lots of dreams easily awakened wake when:

eating pattern regular / not no appetite heartburn indigestion belching vomiting
frequent quickly while reading/TV/computer before sleep

diet macrobiotic vegan vegetarian no red meat lots of dairy eat anything really bad

taste preferences sweet salty sour bitter spicy other:

breathing normal deep shallow painful shortness **nose** normal congested runny bleeding

throat normal dry sore mucous bitter taste thirst choke easily while eat/drinking

cough none frequent dry with phlegm **coldness in:** none feet hands back abdomen other:

headaches none few daily throbbing migraine light headed difficulty concentrating
intensity rating(1-10) location: ____

energy level 0 1 2 3 4 5 6 7 8 9 10 +

body temperature normal hot chills flashes unusual sweat

stiffness in: none neck shoulders upper / lower back tailbone other:

bowel movements regular constipation urgent diarrhea blood in gas times daily:

urination normal yellow frequent bright clear dark cloudy painful blood in

prostate normal inflamed enlarged post-operative impotence premature ejac.

menstruation PMS regular / not painful clotting heavy light clear none
pre- menopausal / post hormonal imbalance other GYN:

pregnancy 0 1 2 3 + regular C-sect. irregular miscarriage terminated other:

Current Activity

please **X** *where appropriate; * = feel free not to answer.*

Activity Amount	Daily	Weekly	Monthly	Rarely	Notes
Exercise					
Vitamins/Herbs					
Sexuality*					
Prescription Drugs					
Recreational Drugs*					
TV/ Computer					
Driving					
Smoking					
Drinking					

Medical History

Please circle any conditions you have or had. add any details you wish, they always help.

Asthma/Resp.	Allergies	Circulation	Depression	Alcoholism
Dehydration	Eating Disorder/Anemia	High/Low Blood Pressure	Arthritis/Joint pain	Bursitis/Tendonitis
Sinus	Diabetes/Hypoglycemia	Chest pain	Nerve/Back pain	Muscle pain
Skin problems	Gland/Hormone	Numb/Dizziness	Seizures	Stress
Grief/Sadness	Worry	Confusion/Instability	Fear/Shock	Anger/Irritable
Nose/Smell	Mouth/Taste	Tongue/Speech	Ear/Hearing	Eye/Vision

Please sign and date the following statement

Shiatsu, Sotai, Toyo Hari or other Meridian Therapies do not constitute medical treatment but are forms of health maintenance utilizing Japanese techniques and principles.

I take responsibility for alerting my therapist to any physical condition which should affect this work. I have consented to a Shiatsu treatment and do not hold the therapist responsible for any adverse reaction to this treatment.

Signed ____

Date ________________