

# Shiatsu Therapy Health History

Shiatsu Therapy treatment is based on an understanding of the whole person. An accurate health history is important to understanding of factors that may have a bearing on your current state of health, and to ensure it is safe for you to receive treatment.

**Information shared in this questionnaire and in dialogue during treatment is confidential and treated with the utmost respect.**

Today's Date: (d/m/yr) \_\_\_\_\_ Your Date of Birth: (d/m/yr) \_\_\_\_\_

NAME: First \_\_\_\_\_ Last \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ Apt. # \_\_\_\_\_ Postal Code \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Ext \_\_\_\_\_ Cell \_\_\_\_\_

E-MAIL: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Did someone refer you? Who? \_\_\_\_\_

Your primary complaint \_\_\_\_\_

Family Physician: \_\_\_\_\_ last check up? \_\_\_\_\_

Are you consulting other health care currently? \_\_\_\_\_

**REASON(S) FOR RECEIVING SHIATSU THERAPY:**

Have you received a professional shiatsu treatment before? No \_\_\_ Yes \_\_\_

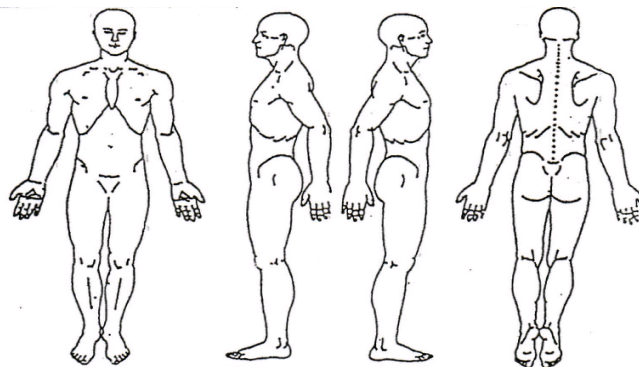
Injury [ please include date(s) ] \_\_\_\_\_

Stress/Relaxation?

To address specific health concerns? (please specify): \_\_\_\_\_

Gift Certificate? From? \_\_\_\_\_

Please mark areas of pain, discomfort or any other symptoms on the pictures below:



**SKIN**

- rashes/ bruise easily
- infectious disease
- contagious skin condition

\_\_\_\_\_

other:

\_\_\_\_\_

**MUSCLES/JOINTS**

*Indicate L/R where appropriate to discomfort.*

- weakness/loss of strength
- clumsiness
- osteoarthritis
- rheumatoid arthritis
- osteoporosis
- tendonitis *location:*

\_\_\_\_\_

strain *location:*

\_\_\_\_\_

sprain/dislocation *location:*

\_\_\_\_\_

artificial joints/pins/  
*location:*

\_\_\_\_\_

**EMOTIONAL**

- anxiety
- depression
- mood swings
- severe stress

Notes:

**RESPIRATORY**

- asthma
  - bronchitis
  - chronic cough
  - difficulty breathing
  - emphysema
  - shortness of breath
  - smoking?
  - other:
- \_\_\_\_\_

**CARDIOVASCULAR**

- high/low blood pressure  
BP?: \_\_\_\_\_ / \_\_\_\_\_
  - bleeding disorder
  - hemophilia
  - arteriosclerosis
  - heart attack
  - heart disease
  - angina
  - stroke / cerebrovascular  
accident
  - pacemaker
  - varicose veins
  - phlebitis
  - poor circulation
  - other:
- \_\_\_\_\_

**HEAD/NECK**

- visual impairment
- \_\_\_\_\_
- hearing impairment
- \_\_\_\_\_
- speech impairment
- \_\_\_\_\_
- sinus problems
  - jaw pain (TMJ pain)
  - headache/migraine
- \_\_\_\_\_

**G.I. CONDITIONS**

- constipation
- diarrhea
- irritable bowel
- hiatus hernia
- ulcers

**OTHER CONDITIONS**

allergies:

\_\_\_\_\_

cancer

\_\_\_\_\_

- diabetes
- fainting
- fever
- insomnia
- numbness/tingling:  
*where?* \_\_\_\_\_
- seizures

**INFECTIOUS CONDITIONS**

- herpes/STD's
- hepatitis: \_\_\_\_\_
- HIV/AIDS
- TB
- FRACTURE

*location* \_\_\_\_\_

SURGERY

*location* \_\_\_\_\_

MOTOR VEHICLE ACCIDENT

**OTHER SYMPTOMS**

**WOMEN ONLY**

- pregnant? due: \_\_\_\_\_
- number of children \_\_\_\_\_
- menstrual difficulties
- gynecological conditions:

# Consent to Treatment - Shiatsu Therapy

Are there any areas of your body that you do not wish to have worked on?

Please be advised that you have the right to refuse or change any or all parts of the treatment now or at any time in the future. Written consent to treatment is provided before the first session. Before all subsequent treatments, verbal consent will be requested before treatment begins.

## Privacy Act Consent

This clinic will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient client care.
- To identify and to ensure continuous high quality service.
- To provide health care in shiatsu or other modalities.
- To advise you of your treatment options.
- To enable us to contact you in order to book or confirm appointments
- To establish and maintain communication with you.
- To communicate with other healthcare providers regarding your care.
- To allow us to efficiently follow-up for treatment, care and billing.
- To comply with legal and regulatory requirements.
- To invoice goods and services.

**I give my consent to treatment**

Client's signature: \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's signature: \_\_\_\_\_