Chokkan Shiatsu & Wellness Services

4601 N. Oakland Avenue, Suite 221
Milwaukee, WI 53208 414/502-7336
www.shiatsuandwellness.com FB: @ShiatsuMilwaukee
Shiatsu • Seiki • Sotai • Craniosacral • Massage • Heartwork™ Coaching

The information provided on your form will be used to discuss your visit with you and to help guide decisions about the program designed to assist and support you in your beauty, health, and wellness goals. Any information gathered from you, whether written or verbal will be held in the strictest confidence and will not be shared in a manner that identifies you without your signed consent. However, observations, conclusions, treatment approaches, and outcomes may be referenced as part of training, lectures, or professional writings. In such instances, under no circumstances will personally identifying information be shared about you.

PART I~

PERSONAL INFORMATION

Name (Last, Middle Initial, First: _____

Email: _____ How often do you check email? _____

Full Address: _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Height: _____ Birthdate: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

How did you hear about True Image BHW? _____

Emergency Contact _____ Phone _____ Relationship _____

SOCIAL INFORMATION

Relationship status: _____

Where do you currently live? _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

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HEALTH INFORMATION

Please list your main health concerns: _____

_____

_____

Other concerns and/or goals? _____

_____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Reached or approaching menopause? Please explain: _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

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MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

_____

Any healers, helpers, or therapies with which you are involved? Please list: _____

_____

What role do sports and exercise play in your life? _____

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

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The most important thing I should do to improve my health is: _____

ADDITIONAL COMMENTS

Anything else you would like to share?