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

Shiatsu is rooted in Chinese medicine and is a wholistic healthcare practice. As a result, the intake process is different than the one you might experience in a traditional healthcare setting. Please complete this intake form to the best of your ability. Except for the blue section immediately below, all of the remaining sections are option. *You do not have to answer any questions you do not want to answer.* However, I will discuss the form with you and the more information you complete, the better I can prepare for our first meeting together. We will discuss your responses at our initial meeting and you will have an opportunity to provide additional details, as you determine appropriate. Your answers can be relatively concise. Please keep your answers on the lines, but try to provide an answer to all the questions presented, if possible.

NAME: ______________________________ **TODAY'S DATE:** ____________
ADDRESS: ____
____
PHONE NUMBER: ________________________ **DATE OF BIRTH:** ____________
EMERGENCY CONTACT NAME: ________________ **RELATIONSHIP:** ____________
EMERGENCY CONTACT NUMBER: ________________
EMAIL ADDRESS ______________________________________
DO YOU HAVE *ANY* ALLERGIES/SENSITIVITIES? ________________________
____
____

1. Tell me a little bit about yourself.
   ____
   ____
   ____
2. How did you hear about Chokkan Shiatsu Wellness Center? Family ☐ Friend ☐ Social Media ☐ My health care practitioner ☐ Internet search ☐ Flyer/Brochure/Business Card ☐ Other ☐ If other, where? ______________________________
3. What type of service are you hear for today? Shiatsu ☐ Massage ☐ Craniosacral Therapy ☐ Reiki ☐ Heartwork™ ☐ Other ☐
4. What is your primary objective for deciding to schedule a session today?
   ____
   ____
   ____
   ____
   ____

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5. Are you coping with chronic pain or fatigue from: Fibromyalgia ☐ ME/CFS ☐ Neurological Disorder ☐ Cancer ☐ Trauma ☐ Stress ☐ Poor lifestyle habits ☐ Dietary challenges ☐ Difficulty with sleep ☐ Other ☐ If other, what? ____
____

6. Tell me a bit about your condition. In what way(s) does it most powerfully affect you?
____
____
____
____
____

7. Do you have any of these other conditions:

Diabetes ☐	Hypertension ☐	Stroke ☐	Phobias ☐
Implant (Any kind) ☐	Hepatitis ☐	Blood Clots ☐	PTSD ☐
HIV/AIDS ☐	Seizure Disorder ☐	Phlebitis/Thrombosis ☐	Disk problems ☐
Pacemaker ☐	Surgery ☐	Whiplash ☐	Repetitive Strain Injury ☐
Bone Break/Fracture ☐	Rash ☐	Migraine/Headache ☐	Carpal Tunnel ☐
Varicose Veins ☐	Pregnant ☐	Sciatica ☐	Communicable Disease ☐
STD ☐	Cancer ☐	Arthritis ☐	Angina☐
Asthma ☐	Spondylitis ☐	IBS ☐	Edema ☐

8. Do you take any supplements or medications? If so, what kind and how often?
____
____
____

9. Do you take any medications or drugs that alter sensation?
____

10. What is the last thing you ate? What time did you eat it? Where/What else were you doing?
____

____
____

11. If you eat any of the following meals, what do you typically eat and at what time?
    Breakfast: ____
    Lunch: ____
    Dinner: ____
    Snacks: ____

12. Are you sleepy during the day and, if so, around what time? Do you know why? Do you nap?
    ____
    ____

13. Tell me about your regular sleep habits. What time do you typically go to sleep? Do you fall asleep right away? Do you sleep soundly through the night? If not, what wakes you?
    ____
    ____

14. Are you retired or employed? What sort of work do you do?
    ____
    ____
    ____

15. How does your work reward you?
    ____
    ____
    ____

16. In what ways is your work a source of stress for you?
    ____
    ____
    ____

17. Tell me about your family life/relationships:
    ____
    ____
    ____
    ____
    ____

18. Are you acting as a caretaker for anyone? No ☐ Yes ☐ If so, who? What do you do for that person?

____
____
____

19. Do you feel safe at home? No. ☐ Yes ☐

20. Do you have any concerns about domestic or sexual abuse?

____

21. What concerns do have about your physical appearance or physical health, if any?

____
____
____
____

22. Do you feel stiff or have joint pain at any time during the day or night?

____
____
____

23. Do you have concerns about your bathroom habits? (E.g., Urination frequency/infrequency; pain; urine or bowel incontinence; constipation; habitual loose stool; etc.)

____
____

24. How is your body temperature, generally?

____
____
____

25. Do you have any spontaneous daytime perspiration? If so, around what times?

____
____

26. Do you have any problems or concerns about your hormonal health? (E.g.: Regularity. Pain/Cramps/Endometriosis. Length. Quality. Menopause.)

____
____

____
____

27. Are you currently sexually active? Yes ☐ No ☐ If yes, are you practicing safe sex? Yes ☐ No ☐

28. Do you have any concerns related to sexual health or reproductive ability? Yes ☐ No ☐ If yes, what concerns you?
____
____

29. Are you currently pregnant or breastfeeding? No ☐ Yes ☐

30. Are your trying to become pregnant but having difficulty? Yes ☐ No ☐
____
____

31. Do you have any concerns related to fertility or sexual function?
____
____
____

32. What do you do for activity/exercise?
____
____
____

33. How is your cardiovascular health?
____
____
____

34. Please list your health concerns in order of priority:
    a) ____
    b) ____
    c) ____
    d) ____
    e) ____

35. Are you seeing a physician or health care provider for any of your conditions? No ☐ Yes ☐ If yes, what kind of physician and what sort of treatment have you had? What was the result?
____

____
____
____
____

36. Have you had any sort of bodywork before (massage, shiatsu, reiki, acupuncture, etc.)?
____
____
____
____

37. Name three things you would like to be doing to improve your health or quality of life that you are not doing now:

    a) ____
    b) ____
    c) ____

38. What is your current height? ____________ Weight? ____________ What was your approximate weight one year ago? ____________

39. Is there anything else you want to tell me?
____
____
____
____
____

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Massage & Bodywork Client Agreement

I, ___________________________________, understand that the massage/bodywork therapies are intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes of massage/bodywork are specified below: The general benefits of massage and bodywork, possible contraindications of massage and bodywork, and the treatment procedure have been explained to me. I understand that massage and bodywork therapies are not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have.

I am aware that the massage/bodywork therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the massage/bodywork therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage/bodywork therapist updated on any changes.

I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted.

I understand and agree to abide by the therapist's polices and will not hold Chokkan Shiatsu &Wellness Services or the therapist responsible for any personal injury or loss of property.

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Client Signature ____

Date ____