



Chokkan Shiatsu & Wellness Services

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www.shiatsuandwellness.com FB: @ShiatsuMilwaukee

Shiatsu • Seiki • Sotai • Craniosacral • Massage • Heartwork™ Coaching

Client Health History

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Date: _____

Patient name: _____

Parent/Guardian name: _____

(if applicable)

Address: _____

Tel: Home _____

Business _____

Cell _____

Email: _____

Receive occasional emails? Yes No

How would you like your appointment reminder?

Phone: Email:

Occupation: _____

Birth date: _____

Did a health care practitioner refer you?

Yes No

If yes, please provide their name and address:

Primary Care Physician: _____

Address: _____

Telephone: _____

Overall, how is your general health? _____

What is the reason you are seeking treatment? Please include the location of any tissue or joint discomfort.

Are you currently receiving treatment from another health care professional? Yes No

If yes, for what? _____

Current

Medications and/or remedies: _____

Conditions being treated: _____

What other treatments have you received? _____

Have you ever received massage therapy before?

Yes No

Past

Injuries (nature and dates): _____

Surgery (nature and dates): _____

Client Health History continued

Please indicate conditions presently causing problems, as well as conditions which were a problem in the past.

BABIES & CHILDREN

	Present	Past
Birth trauma.....	<input type="checkbox"/>	<input type="checkbox"/>
Feeding problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Colic.....	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness/sleep problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent earinfections.....	<input type="checkbox"/>	<input type="checkbox"/>
DevelopmentalDelays.....	<input type="checkbox"/>	<input type="checkbox"/>
Behavioural issues.....	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity/ADD/ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye motor problems.....	<input type="checkbox"/>	<input type="checkbox"/>
PDD/autism.....	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

	Present	Past
Chronic cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

	Present	Past
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/varicose veins.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular aneurysm.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/other device.....	<input type="checkbox"/>	<input type="checkbox"/>
Coldness in extremities.....	<input type="checkbox"/>	<input type="checkbox"/>

DIGESTIVE CONDITIONS

	Present	Past
Please describe:	<input type="checkbox"/>	<input type="checkbox"/>

INFECTIONS

	Present	Past
Skin conditions/infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
HIV.....	<input type="checkbox"/>	<input type="checkbox"/>
TB.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN

	Present	Past
Gynecological conditions.....	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant, due.....	<input type="checkbox"/>	<input type="checkbox"/>

HEAD/NECK

	Present	Past
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Migraines.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaw problems (pain/clicking/locking).....	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash.....	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems or loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear problems or hearing loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinusproblems.....	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Closed head injury.....	<input type="checkbox"/>	<input type="checkbox"/>
Other neurological conditions.....	<input type="checkbox"/>	<input type="checkbox"/>

OTHER CONDITIONS

	Present	Past
Epilepsy/seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: where.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis: family history.....	<input type="checkbox"/>	<input type="checkbox"/>
Susceptible to colds/infections.....	<input type="checkbox"/>	<input type="checkbox"/>
High stress levels.....	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia.....	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness.....	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling/loss of sensation.....	<input type="checkbox"/>	<input type="checkbox"/>

EVERYONE

Is there any other information your therapist should know?

Presence of internal pins, artificial joints, or special equipment

Known allergies or hypersensitive reactions?

Other diagnosed diseases or medical conditions?

Is there any other information that you would like to provide?
