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

Massage Intake Form

Personal Information

Name _____ Phone (day)_____(evening) _____

Address _____ City/State/Zip_____DOB _____

Occupation_____Employer _____

Email_____Primary Physician _____

Emergency Contact_____Relationship_____Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse?_____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list:_____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other ___ __ _ __ __ __ __ __ _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

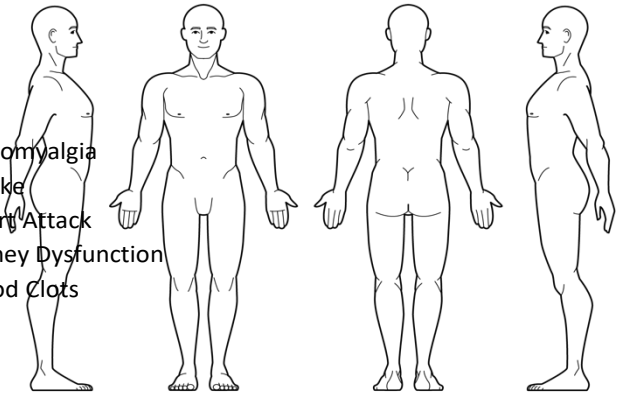
Please explain _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain_____

What are your goals for this treatment session?

_____ Please circle any areas of discomfort



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☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

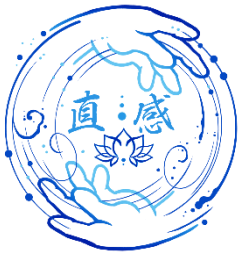
_____

_____

By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____



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