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

Sotai 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?______________

____

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
- ☐ Numbness
- ☐ Sprains or Strains

Sotai Information

Which of the following is more important to you today?

☐ Relaxation ☐ Chronic Pain Relief

☐ Other ______________________

Have you ever had any of the following:

☐ Falling ☐ Injury ☐ Surgery ☐ Pulled Muscle

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

Please explain ______________________

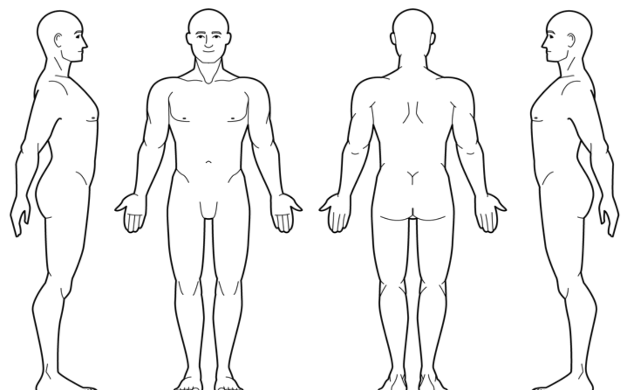
Are there any areas (feet, face, abdomen, etc.) you do not want touched? ☐ yes ☐ no

Please explain______________________

What are your goals for this treatment session?

____

Please circle any areas of discomfort



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Explain any conditions you have marked above:

____

____

____

____

Do you have any other conditions that might affect this bodywork session?: If so, what?

____

____

____

____

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* ____________