Shiatsu

PATIENT INFORMATION SHEET

Name_____Phone_____

Address_____ Postal Code: _____

Age_____Height_____Weight_____

Birthplace_____Time_____Date_____

Marital status_____# of people living at home_____

Occupation_____Business phone_____

Interests/hobbies_____

Physical activity/exercise_____

1) Why are you coming for treatment?

_____

2) Major complaints

_____

3) Medical history of yourself

_____

_____

_____

4) Family medical history

_____

_____

_____

5) How would you describe yourself emotionally?

_____

_____

6) What is your favorite color?

_____

7) What season(s) do you like/dislike?

_____

8) What climate(s) do you like/ dislike?

_____

9) At what time(s) of day do you feel better or worse?

_____

10) What is your favorite taste?

_____

11) Do you have any trouble with your head (headaches, dizziness?)_____

12) How are your eyes? _____

13) How are your ears? _____

14) How is your nose? _____

15) How is your skin? _____

16) How are your nails? _____

17) How is your urination?

Often_____Green_____Yellow_Clear_____Cloudy_

18) How do you sleep? (do you wake up tired?)

_____

19) What do you drink? (how often?) _____

20) Type of diet (i.e. Largely meat, dairy or starch, vegetarian, etc.):

_____

_____

_____

21) Do you use alcohol, tobacco, or drugs?_____

_____

22) Do you take any medications? (prescribed or over the Counter?) _____

_____

23) Describe your menstrual cycle (regular? How long? Any Discomfort? Depression ? Ever pregnant?) _____

_____

_____

24) How is your circulation?_____

25) List all areas of physical tension (i.e. Lower back, neck, shoulders, etc.)

_____

_____

26) Are you experiencing any emotional stress? (family problems, jobs, etc.?)

_____

_____

27) Are you currently under a doctor's care for a specific problem?

_____

Any additional information? (use back of page)

_____

_____

Date:_____Signature:_____