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Traditional Naturopathy, Shiatsu & Yoga
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SHIATSU CLIENT HEALTH AND LIFESTYLE PROFILE

Date: _____ Name:_____ Date of Birth:_____

Phone:__Home_____ Office _____ Mobile _____

Address _____

Email: _____Referred by: _____

Main problem: _____

Most bothering symptom(s) TODAY (or Most desired improvement TODAY): _____

_____

Today/ present period – on a scale from 1 to 10: Intensity of symptom: ____ Frequency:_____

Family/ Primary relationship status: _____

Type of employment/daily activities: _____

_____

Exercise frequency/type: _____

Diet Summary: (describe your diet in general): _____

_____

_____

Drinks: water ..... tea..... coffee.....sodas .....other……

Any weight loss diets: Y/ N. If Yes: Which and when: _____

Digestion pattern/ Numbers of daily / weekly bowel movements: _____

--------Women: # of children: ___ Ages _____ Pregnancy problems:_____ Abortions:_____

Last Period:____ Type of period, PMS problems: _____ Birth control: Y/ N

Smoking: N / Y – How much: _____ Since: _____ Alcohol: daily consumption: _____

Medications you are taking _____

Supplements: _____

History of problems & surgeries:

Problem	Year	Solved? How?	Today – still treated? Medications?	Impact on today's life (1 to 10)

Mark an X on the right of any of the symptoms or physical problems listed below that you are currently experiencing or have experienced. It is important to be very open and honest with your therapist. All the information in this form and any subject discussed during the session will be kept strictly confidential.

Allergies		Fatigue		Arthritis	
Respiratory/Lungs		Weakness		Osteoporosis	
Skin disorders		Numbness		Osteopenia	
		Poor memory		Other musculoskeletal	
Diabetes		Epilepsy		Sciatic pain	
High/Low blood pressure		Emotional disorders (Depression/ Anxiety/ Bi-Polar/ Other)			
Headaches		Speech difficulties		Hearing	
Cardiovascular/ Heart		Dizziness		Vision	
		Insomnia		Contact lenses	
Hormonal imbalance		Stress			
Indigestion		Frequent colds		Cancer	
Flatulence		Other immune system problems			
Ulcer		AIDS		Addictions	
Collitis/ IBS/ Crohn's		Other problem(s):			
Reflux					

Last blood tests date: _____

If you have ever seen a natural healthcare professional before, what type, when, and for what reason? _____
_____
_____

Emergency Contact (Name, Phone number): _____

DISCLAIMER

I understand that the Shiatsu session is provided for the basic purpose of relaxation, energy balancing and relief of muscular tension.

Zen Shiatsu is NOT supposed to be painful. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure may be adjusted to my individual level of comfort. I further understand that Shiatsu should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician for any medical or physical ailment of which I am aware. I understand that Shiatsu therapists are not qualified to diagnose, prescribe or treat physical or mental illnesses and that nothing said in the course of the session given should be considered as such. To avoid confusing usage of medical language, the term used for the receiver of a Shiatsu session will be "client" instead of "patient".

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

_____ _____

Client Signature Date

We are reserving the time of your appointment solely for you. Please keep your appointment or let us know at least 24 hours in advance if you need to reschedule.

Thank you,

Angie Shapira - Natural Choice For You ™