

Intake Form

Name _____ DOB ____/____/____ Female Male
Home Address _____ Home Phone# ____-____ Cell / Pager # ____-____
City/State/Zip _____ Occupation _____
Referred By _____
Emergency Contact _____ Emergency Phone # ____-____

What is the reason for your visit today? _____

Have you had a Shiatsu treatment before? Yes No Have you had CranioSacral treatment before? Yes No
Have you ever received any type of body work before? Yes No If yes, what type? _____

Do you suffer from any of the following?

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contagious Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain _____	
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have any other serious medical condition I should be aware of? _____

Have you ever had surgery? _____ Explain _____

In the past 2 years have you: Had any broken bones? Yes No Explain _____

Have you had injuries? Yes No Explain _____

Do you bruise easily? Yes No Do you suffer from back pain? Yes No

Are you sensitive to touch in any area? Yes No If so where? _____

Are you taking any medication? _____

What herbs or supplements do you take? _____

Do you exercise? ____ What type? _____ How often? _____

Do you smoke? ____ Drink alcohol? ____ How often? ____ Do you drink coffee? ____ How many cups a day? ____

Average hours of sleep a night? ____ Are you pregnant? Yes No

How would you describe your overall stress level? Low Medium High

When faced with a stressful situation, how do you feel? (check all that apply)

<input type="checkbox"/> anger	<input type="checkbox"/> sad	<input type="checkbox"/> frustrated	<input type="checkbox"/> anxious	<input type="checkbox"/> hostility
<input type="checkbox"/> worry	<input type="checkbox"/> depressed	<input type="checkbox"/> overwhelmed	<input type="checkbox"/> fearful	<input type="checkbox"/> other

I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand if I experience any pain or discomfort I will inform the practitioner immediately. I take responsibility for alerting my practitioner to any physical conditions which would effect this work.

Signed _____ Date _____

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