

Sky Blue Shiatsu Health History

This questionnaire will help us design a treatment specific to your concerns and is held confidential by Sky Blue Shiatsu. It will not be released without your written consent.

Name _____

Address _____ Zip code _____

Phones(s) _____

Date of Birth _____ Age _____ Height _____ Sex M F

Occupation _____ Do you? sit stand lift

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Have you had Shiatsu before? _____

Other bodywork or therapies? _____

Are you currently being treated by anyone? _____

For what condition? _____

What are you main concerns today? _____

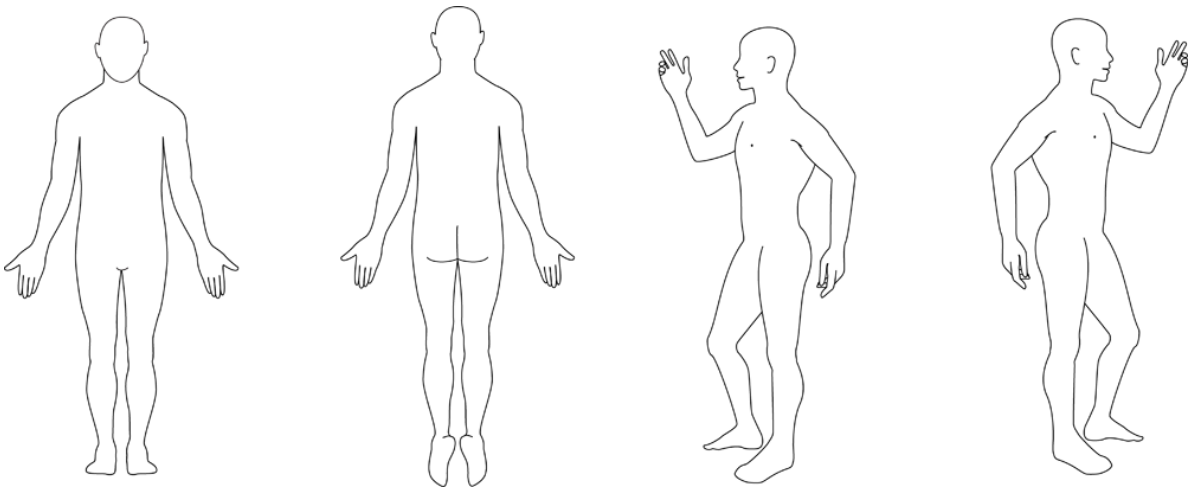
What is your hoped for outcome? (Check all that apply)

relaxation/stress relief increased energy increased strength pain relief emotional release

improved athletic performance injury recovery learn some new stretches increased flexibility

other _____

Mark any affected areas on the diagrams below and describe the problem: pain, swelling, numbness, stiffness, tight, aching, disc problem, arthritis, etc...



Do you have problems with fatigue or weakness? All the time A.M. P.M.

General History (please check all that apply)

Sleep patterns

_____, hours per night

- heavy sleeper
- light sleeper
- dream disturbed
- difficulty falling asleep
- difficulty staying asleep
- wake from pain
- night sweats

Predominant Emotions

- anger
- anxiety
- depression
- fear
- grief
- indecisiveness
- irritability
- happiness
- joy
- sadness
- stress

Head and Face

- Migraine
- Headache
- _____ frequency
- _____ duration
- _____ location

- concussion
- head injury
- TMJ
- Jaw pain
- clicking jaw
- grind teeth
- teeth problems
- dry mouth
- sores in mouth

- ear ache
- ringing in ears
- ear infection
- hearing loss

- dry eyes
- spots in vision
- blurred vision
- glasses or contacts
- night blindness
- cataracts

Neurological

- seizures
- dizziness
- loss of balance
- poor memory
- poor coordination

Cardiovascular

- heart palpitations
- high blood pressure
- low blood pressure
- chest pain
- irregular heartbeat
- fainting
- cold hands/feet
- swelling hands/feet
- sweaty hands/feet

Respiration

- asthma
 - hard to breath in
 - hard to breath out
 - triggered by cold
 - triggered by exercise
 - use an inhaler

- shallow breathing
- sigh a lot
- easily winded
- weak voice
- frequent colds
- bronchitis
- pneumonia
- sinus infections

- allergies
 - perfumes
 - chemicals
 - hay fever
 - animals
 - foods

Urination

- frequent
- infrequent
- wake up to urinate
- pain with urination
- unable to hold urine
- blood in urine
- dark urine
- clear urine
- urinary tract infections
- bladder infections
- kidney infections
- kidney stones

Skin

- dry skin
- oily skin
- acne
- rashes
- open sores
- warts
- athletes foot
- bruises
- bruise easily
- lumps
- moles
- anything I shouldn't press on? _____

Gastrointestinal

- nausea
- vomiting
- loose stools
- diarrhea
- constipation
- black stools
- blood in stools
- gas
- belching
- indigestion
- stomach acid
- frequent hunger
- poor appetite
- abdominal pain
- bloating

Female clients

- menstruation
- heavy _____ days
 - medium _____ days
 - light _____ days
- _____ days in cycle
- irregular menstruation
 - painful menstruation
 - blood clots
 - ovarian cyst
 - yeast infection/discharge
 - endometriosis
 - infertility
 - menopause
 - hysterectomy at age _____
 - pregnancies, _____
 - miscarriages _____
 - abortions _____
 - currently pregnant
- how many months? _____
- Change in body/psyche prior menstruation, _____

Current/Past History

- herniated disks
- osteoporosis
- arthritis
- smoking
- eating disorder
 - bulimia
 - anorexia
- cancer
- HIV/Aids
- hepatitis
- heart disease
- rheumatic fever
- thyroid disease
- hemia
 - hiatal
 - inguinal

Lifestyle

(check all that apply & write in amounts)

Habits

- cigarettes _____/day
- alcohol _____ drinks/week
- coffee _____ cups/day
- tea _____ cups/day
- soda pop _____ cans/week
- other _____

Exercise and other activities

Do you exercise? yes no Times per week. _____

Do you stretch? yes no Times per week. _____

- walk
- run
- bike
- swim
- skate
- golf
- tennis
- basket ball

- dance
- aerobics
- other
- ski
- downhill
- cross country
- weight lifting
- gymnastics

- yoga
- tai chi
- qi gong
- meditation
- gardening
- martial arts
which _____
- other _____

Please describe your average daily diet. _____

Please list any injuries, accidents or falls with the dates and any recurring problems. _____

Please list any diseases, surgeries or illnesses you now have or have had, and any recurring problems

Please list any emotional trauma, abuse, death, loss, etc. _____

Please list any medications, herbs, supplements or over the counter medicines you take _____

Is there anything else I should know about you ? _____
