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)

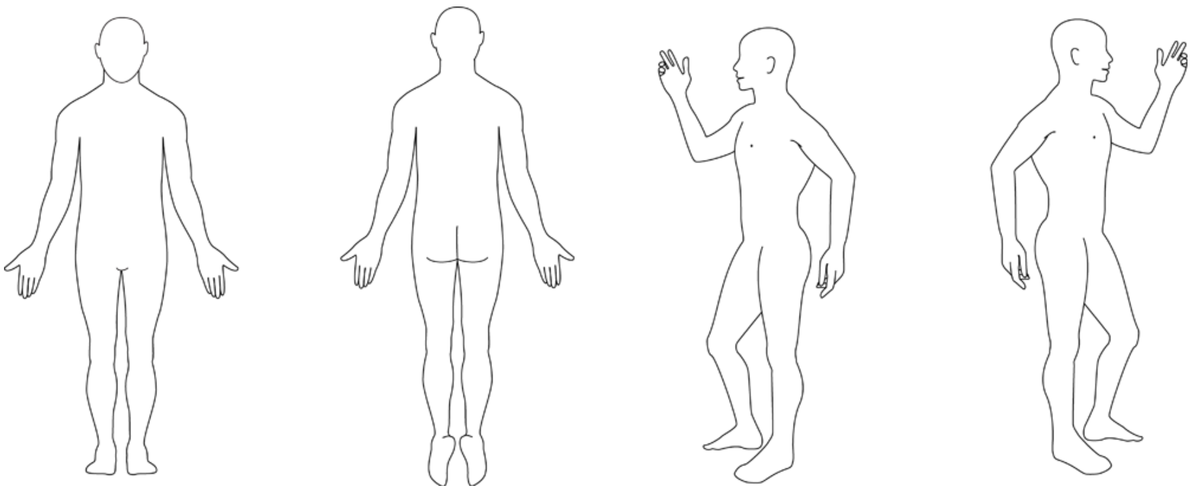
☐ relaxation/stress relief ☐ increased energy ☐ increased strength ☐ pain relief ☐ emotional release

☐ 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...

____



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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

Male clients

- [ ] burning urination
- [ ] urinary incontinence
- [ ] impotence
- [ ] prostatitis
- [ ] premature ejaculation
- [ ] nocturnal emissions
- [ ] painful/swollen testicles
- [ ] other_______________

____
____

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

Lifestvle

(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. ____

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____

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

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____

____

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

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____

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Please list any emotional trauma, abuse, death, loss, etc______________________________

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

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Is there anything else I should know about you ?______________________________

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