Health History Form

Thank you for taking the time to fill out this questionnaire. The information provided allows me to create a treatment that is appropriate for you. The first page is essential information. The pages following are for those of you interested in exploring Shiatsu and the treatment principles of Traditional Chinese Medicine. **All of your information is and held strictly confidential.**

Name: _____ Date: _____

Address: _____City/State Zip: _____

Phone number(s) you prefer to be reached at:_____

E-mail address: _____Emergency Contact:_____

Phone: _____Date of Birth: _____

Occupation:_____

Current Health Care Professional: _____Phone: _____

Have you had professional bodywork before? _____Main concern(s) you would like help with today: _____

_____

Please answer the questions below and elaborate in the space provided for any "yes" answers.

Do you wear contact lenses or dentures?_____

Are you sensitive to perfumes, lotions, or oils? _____

Do you exercise regularly or participate in any sports? _____

_____

Do you have any skin problems or allergies? _____

_____

Have you experienced an illness or injury recently? _____

Do you have any heart problems? _____

_____

Do you have high blood pressure? _____

_____

Do you have varicose veins?_____

Do you have arthritis, osteoporosis, brittle bones, or spinal problems? _____

_____

Do you have lung or breathing problems? _____

_____

Do you have digestive track problems? _____

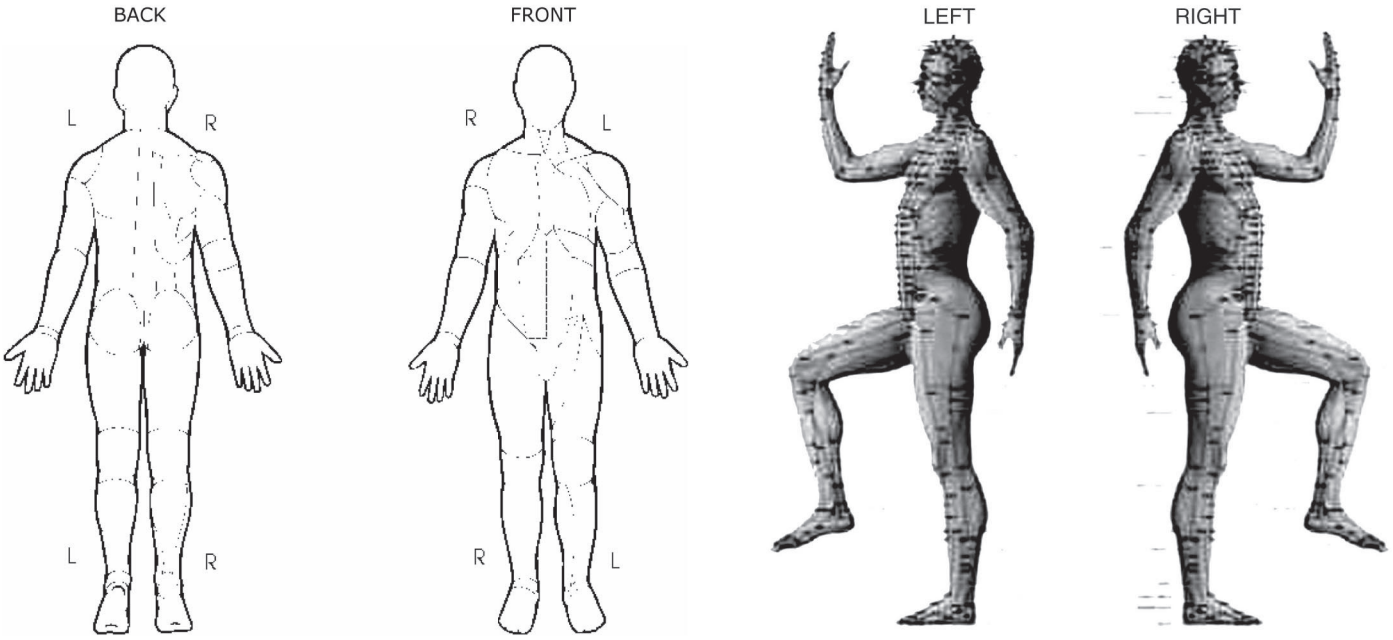
_____

Are you pregnant?_____

Do you have other health problems I should be aware of? _____

_____

Please mark any areas of pain or tension on the diagrams below:



_____

_____

_____

_____

-- Only this first page is essential information --

The following pages are for those of you interested in exploring Shiatsu and the treatment principals of Traditional Chinese Medicine.

LIFESTYLE HISTORY

Please check all that apply and write in amount in the space provided:

	Smoke cigarettes
	Drink Alcohol
	Drink coffee
	Drink tea
	Drink colas

	Use laxatives
	Take aspirin
	Psychotherapy
	Exercise
	Meditate

Occupation _____How long?_____

Work related stresses (physical, chemical, emotional) _____

Please describe your sleep patterns: _____

Please describe your average daily diet _____

Please list the one or two emotions that seem to predominate your life _____

Please mark which flavor you like **most** : _____sweet _____salty _____ bitter _____spicy_____sour

Please mark which flavor you like **least**: _____sweet _____salty _____ bitter _____spicy_____sour

PAST MEDICAL HISTORY

	Cancer
	Diabetes
	Hepatitis
	High Blood Pressure
	Asthma

	Heart Disease
	Rheumatic Fever
	Thyroid Disease
	Seizures
	Pneumonia

	AIDS/HIV
	Venereal Disease
	Drug/Alcohol Addiction
	Frequent Colds/Flu
	Bronchitis

Allergies (please describe)_____Other (please describe)_____

Significant physical trauma (auto accidents, physical abuse, work related accidents, etc) _____

_____ Date(s) _____

Describe _____

Significant emotional trauma (divorce, death, abuse, major life changes) _____

_____ Date(s) _____

Describe _____

Surgeries and /or previous serious illnesses: _____

_____ Date _____

Describe _____

_____

_____

Please list any diseases, deaths and their causes of your immediate family: _____

_____ Date _____

Describe _____

_____

_____

ADDITIONAL COMMENTS

Feel free to provide any further information you feel is important which may not have been covered in this questionnaire: _____

_____

_____

_____

_____

_____

_____

_____

PLEASE CHECK ALL THAT APPLY

	GENERAL
	Heavy sleep
	Dream-disturbed sleep
	Difficulty falling asleep
	Difficulty staying asleep
	Fatigue
	Fevers
	Chills
	Night sweats
	Sweat easily
	Tremors
	Cravings
	Change in appetite
	Bleed/bruise easily
	Weight loss
	Weight gain
	Peculiar tastes/smells
	Edema
	Dislike cold
	Dislike heat
	Reduced sexual energy
	Lymphatic swelling
	Varicose veins
	Prefer warm drinks
	Prefer cold drinks
	Sudden energy drop
	Time of Day_____
	MUSCULOSKELETAL
	Neck pain
	Muscle pain
	Knee pain

	Back pain
	Foot/ankle pain
	Hand/wrist pain
	Shoulder pain
	Hip pain
	Muscle weakness
	Swollen joints
	Numbness
	Tremors
	Other_____
	RESPIRATORY
	Oppression in chest
	Chest pains
	Distension in chest
	Heat in chest
	Shallow breathing
	Panting
	URINATION
	Frequent urination
	Wake up to urinate
	Pain when urinating
	Decrease in urination
	Unable to hold urine
	Blood in urine
	Dark colored urine
	Clear urine
	Dry eyes
	Other_____
	CARDIOVASCULAR
	Heart palpitations
	High blood pressure

	Low blood pressure
	Chest pain
	Irregular heartbeat
	Fainting
	Cold hands/feet
	Swelling of hands
	Swelling of feet
	Blood clots
	Hot hands and feet
	Sweaty hands and feet
	Other_____
	NEUROPSYCHOLOGICAL
	Seizures
	Dizziness
	Loss of balance
	Areas of numbness
	Lack of coordination
	Poor memory
	Concussion
	Depression
	Anxiety
	Irritable
	Have anger
	Lose temper easily
	Indecisive
	Fearful
	Easily stressed
	Thoughts of suicide
	Other_____

PLEASE CHECK ALL THAT APPLY

HEAD AND EYES	
	Wear glasses
	Poor vision
	Night blindness
	Colorblindness
	Cataracts
	Spots in front of eyes
	Blurry vision
	Eye strain
	Eye pain
	Migraines
	Headaches: where:_____
MALE CLIENTS ONLY	
	Burning urination
	Urinary incontinence
	Impotence
	Prostatitis
	Premature ejaculation
	Nocturnal emissions
	Painful/swollen teste
	Other_____
EAR, NOSE & THROAT	
	Earaches
	Ringing in ears
	Poor hearing
	Sinus problems
	Nose bleeds
	Recurrent sore throats
	Grinding teeth
	Facial pain
	Sores on lips/tongue
	Teeth problems

	Jaw clicks
	Dry mouth
	Excessive saliva
SKIN AND HAIR	
	Dry skin
	Dry hair
	Dandruff
	Loss of hair
	Oily skin
	Oily hair
	Acne/pimples
	Open sores on skin
	Skin rash
	Itching
	Eczema
	Cysts/tumors _____
	Other_____
RESPIRATORY	
	Weak voice
	Cough
	Coughing up blood
	Phlegm
	Difficulty breathing
	Other _____
GASTROINTESTINAL	
	Nausea
	Vomiting
	Loose stools
	Diarrhea
	Constipation
	Black stools
	Blood in stools

	Gas
	Belching
	Ndigestion
	Bad breath
	Hemorrhoids
	Stomach acid
	Low body weight
	Frequent desire to eat
	Disinterest in eating
	Abdominal pain or cramps
	Abdominal bloating
	Gurgling in stomach
FEMALE CLIENTS ONLY	
	Heavy menses-____ days
	Light menses-_____ days
	Irregular menses
	Painful menses
	Blood clots
	Ovarian cyst
	Yeast infection/discharge
	Endometriosis
	Infertility
	Menopause
	Hysterectomy at age_____
	Pregnancies_____
	Miscarriages_____
	Abortions_____
	Currently pregnant?
	How many months
	Changes in body or psyche prior to menses
	Other_____