QI SHIATSU Client Information / Physical History

The information requested on this form will be used to design a Shiatsu massage therapy plan best suited to your needs. All information will remain confidential.

Name: _____ D.O.B: _____

Address: _____ Phone #: _____

City/State/Zip:_____Email: _____

How would you prefer to be contacted? _____ Call _____ Text _____ Email

Would you like to occasionally be contacted regarding promotions, newsletters, etc? ____Yes____No

Occupation: _____ Recreational activities: _____

In case of emergency, contact _____ (name)

Phone #: _____ Relationship: _____

Have you received massage therapy before? _____ No _____ Yes – what type (i.e. Swedish, deep tissue, sports, Thai, etc.)

How did you learn about these services?

Please list any chronic illnesses, operations, or traumatic accidents you have experienced, providing brief explanation and dates.

Please list any medications you take, including name & dosage if possible.

Are you currently under the care of a physician, chiropractor, or other health care practitioner? If yes, who and for what condition(s)?

Do I have permission to contact your health care practitioner if necessary? _____Yes _____No

Do you have any allergies / sensitivities to nuts, foods, oils, fragrances, etc? If so, please list:

(please see other side)

Please place a check mark next to any of the following illnesses or conditions that you currently are experiencing or have experienced in the past:

_____ Arthritis	_____ Asthma	_____ Diabetes
_____ Joint Pain	_____ Carpal Tunnel pain	_____ Blood clots
_____ Headaches	_____ Sciatica	_____ Digestive disorder
_____ Migraines	_____ Insomnia	_____ Varicose veins
_____ Shoulder pain	_____ Dizziness	_____ TMJD (jaw clenching/teeth grinding)
_____ Neck pain	_____ Herniated disc	_____ Skin infection/disorder
_____ Back pain	_____ Fibromyalgia	_____ Edema
_____ Bruise easily	_____ Cancer	_____ Low/high blood pressure
_____ Pregnancy	_____ OTHER (please specify):	

CONSENT FOR TREATMENT

I have completed this health form to the best of my knowledge and will inform my massage therapist of any changes that occur. I do understand that Shiatsu massage therapy and bodywork services are designed to be a therapeutic health aid and DO NOT take the place of a physician's care.

My health file and information will be kept confidential, and unless required by law, any release of information must have written authorization from me.

I understand that the nature and purpose of the treatment will be explained to me, and I further understand the potential for mild temporary side effects from massage, including but not limited to muscle soreness, mild bruising, and light-headedness.

I understand that I have the right to stop or modify the treatment at any time, as does the massage therapist.

If I am unable to keep a scheduled appointment, I agree to cancel at least 12 hours in advance. Unless there is emergency or illness, I understand that if I miss a scheduled appointment, I agree to pay the full appointment fee.

I am responsible for payment at time of service, unless other arrangements have been made.

Signature: _____ Date: _____

(if patient is a minor, parent/guardian signature): _____