Health History

Name____ Date____________________

Address____

________________________Occupation___________________________________

Phone (Home):__________________(Business);____________________Birthdate:_______________

Why do you want shiatsu treatment?____________________________________

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Referred by:____

Do you have any physical complaints or discomforts? Explain.________________

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Have you ever had any operations, accidents or illness?

Explain type and Date:____

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Are you taking any medication or supplements?___________________________

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What is your general diet? (Standard American, vegetarian, etc.)

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Do you exercise? If so what kind______________________________________

When stressed (out of balance) how do you generally feel?

Worried	Angry	Frustrated
Sad	Depressed	Overwhelmed
Nervous	Fearful	Other____________________

Do you experience any of the following:

High blood pressure	Heart problems	Headaches	Arthritis
Digestive disorders	Pain or numbness	Sleeplessness	Aneurysm
Are you pregnant?	Joint pain	Allergies	Varicose veins
TMJ	PMS	Other____________________	