



2927 SE 71st Avenue

Portland, OR 97206

503.233.2236 **Phone**

503.233.3918 **FAX**

shiatsu@theshiatsucenter.com **Email**

www.theshiatsucenter.com **Web**

CONFIDENTIAL INTAKE FORM

PART 1

PATIENT INFORMATION

Date of First Visit _____

Birth Date _____

Mo / Day / Year

Name _____

Last

First

MI

Street Address _____

City _____ State _____ ZIP _____

Home Phone _____

Work Phone _____ Cell _____

Email Address _____

Occupation _____

Referred by _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

PART 2

Are you taking any medication? Yes No

If yes, please list _____

If you know your blood pressure and resting pulse rate and / or recent cholesterol level, please indicate:

_____/_____/_____
BP _____ Pulse _____ Cholesterol

Have you had any injuries, illness or surgery? Yes No

If Yes, please indicate _____ Date(s) _____

Type Auto Work Related Other

Describe _____

Do you wear contact lenses? Yes No

Please check any problems/conditions that apply to you:

- | | | | |
|------------------------------------|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cough | <input type="checkbox"/> Low BP |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menopause | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menses |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Influenza | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Skin | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Varicose Vein |

Comments _____

PART 3

Financial Policy. We ask our clients to pay at the time of each visit unless specific arrangements have been made.

Return Checks. Returned check fee is \$25.00

Cancellation Policy. The time of your appointment is reserved for you! Please give at least 24 hour advance notice if you will be unable to keep your appointment. You will incur a charge of 50% for appointments cancelled less than 24-hour notice except in the case of an emergency, you will incur a charge of 80% for missed appointments.

Late Payments. 1.5% interest charge assessed per month or 18% annually.

I have read and understand the information above

Client Signature

Date

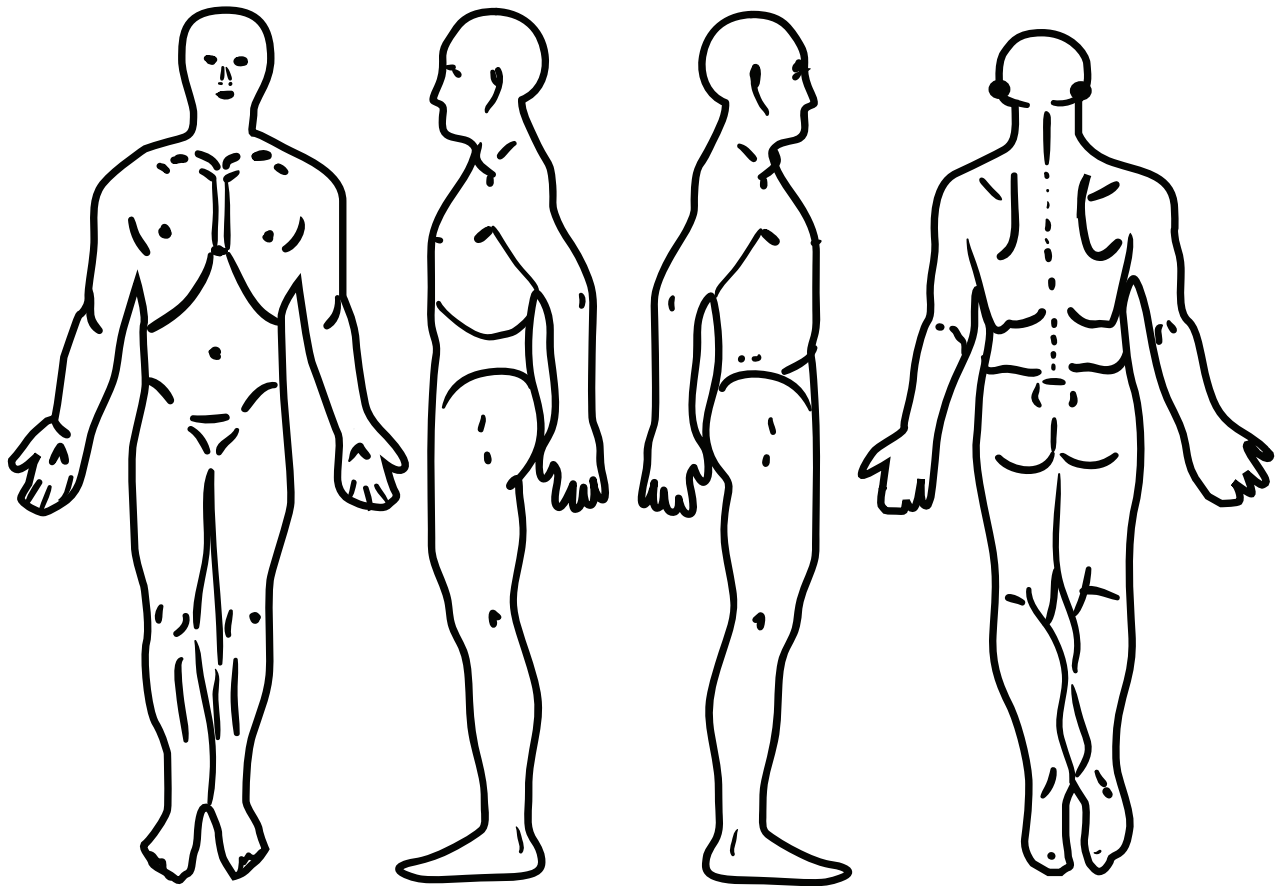
I understand that this work does not constitute medical treatment, but is a form of health maintenance. I take responsibility for alerting my physician to any physical condition which would affect my work

Client Signature

Date

PAIN CHART

Please circle your troubled areas in this diagram



When do you feel pain? _____

Are you in pain now? Yes No

Have you previously had:

How often?

Shiatsu Treatment Yes No

Massage Yes No

Acupuncture Yes No

Chiropractic Yes No

