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:

❑ AIDS	❑ Constipation	❑ Cough	❑ Low BP
❑ Acne	❑ Diabetes	❑ Menopause	❑ Depression
❑ Allergies	❑ Diarrhea	❑ Fatigue	❑ Menses
❑ Arthritis	❑ Gout	❑ Hey Fever	❑ Nausea
❑ Bladder	❑ Headache	❑ Heart	❑ PMS
❑ Cancer	❑ High BP	❑ Hypertension	❑ Pregnancy
❑ Cold	❑ Influenza	❑ Insomnia	❑ Prostate
❑ Sinus	❑ Skin	❑ Sore Throat	❑ 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

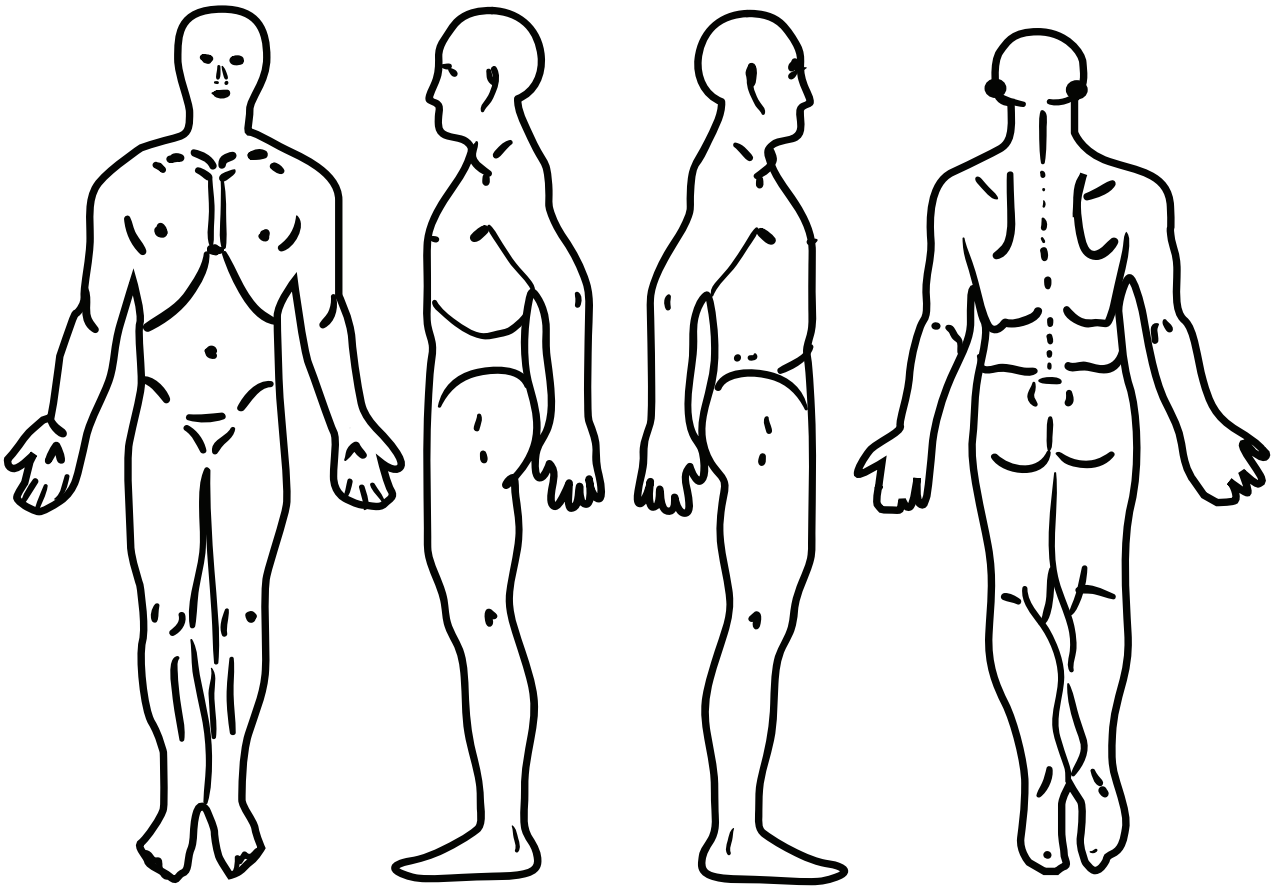
I understand that this work does not constitute medical treatment, but is a form of health maintenance. I take responsibility for alerting my physician to any physical condition which would affect my work

_____ _____

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	_____