Questionnaire

Although the prevalent view in shiatsu is a holistic one, and not primarily oriented toward fixing symptoms, answering the following questions about your complaints and their patterns is very helpful in developing a viable treatment approach. *Even if you seek shiatsu "just" as a way to relax it's very helpful when you answer all the questions you feel are relevant.*

How did you hear about Axishiatsu? _____
_____

□ Please put me on your mailing list □ No, I'd rather not be on your mailing list

Date	Occupation
Name	How many hours per week do you work?
Address	Do you enjoy your work?
Postal Code and City	Have you had shiatsu before? □ Yes □No
Telephone(s)	Who to contact in case of emergency
	Emergency contact's telephone number
Email	
Date of birth	Sex □M □F
Primary care physician	

Current Condition

Main problem(s) you would like help with_____
_____
_____
When did they begin? Be specific._____
_____
_____
To what extent do these problems interfere with/affect your life? _____
_____
_____
Do you have a specific diagnosis from a health profession? What is it and who gave it? _____
_____
_____
What treatments have you tried? What has helped?_____
_____
_____

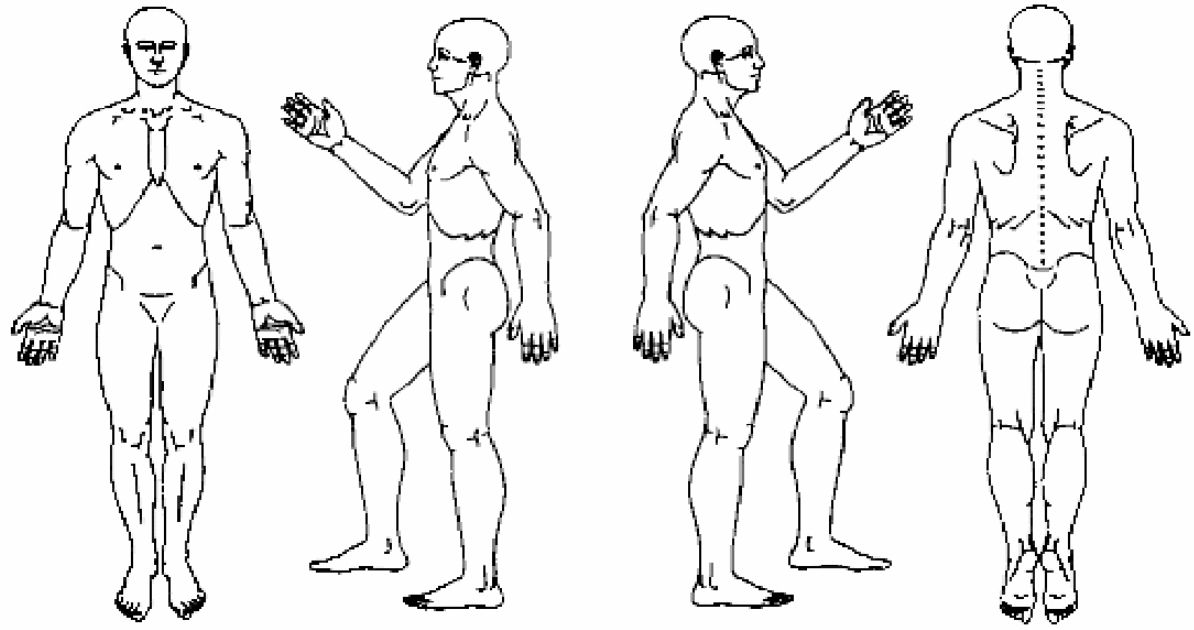
What medications (drugs, herbs, oils, over-the-counter medications, vitamins etc) are you currently using? _____
_____

Family History

Please check any occurrence of the following in your family's history

☐ Heart disease	☐ Cancer	☐ Mental illness	☐ Kidney disease
☐ Diabetes	☐ Osteoporosis	☐ Thyroid condition	☐ Respiratory disease
☐ Arthritis	☐ Alzheimers	☐ Liver condition	

Body Pain Chart



Please circle the areas on the body you are seeking help with. Please place an X on any recently injured areas, varicose veins or areas you do not wish treated or touched.

Please tell me more about the type of pain you experience

Please check all that apply

☐ Pain always in the same area(s)	☐ Stiffness, cramping	☐ Feels better with pressure
☐ Pain moves around	☐ Hot or swollen	☐ Rest helps
☐ Pain is related to an injury	☐ Area feels cool	☐ Movement helps
☐ Pain mostly in the joints	☐ Sharp and stabbing	☐ Worst in cold weather
☐ Pain mostly in the muscles	☐ Dull- aching	☐ Numbness or heavy sensation
☐ Pain limits movement	☐ Feels better with cold	
	☐ Feels better with heat	

Please list any significant physical trauma (auto accidents, injuries, surgeries, stress, physical abuse, etc.)

Date _____ Description _____

Date _____ Description _____

Please list any significant emotional trauma (divorce, deaths, difficult changes)

Date _____ Description _____

Date _____ Description _____

Personal health history

Please check all that apply

- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Asthma
- ☐ Allergies- please describe
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Thyroid disease
- ☐ Seizures
- ☐ Pneumonie
- ☐ AIDS/HIV
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other STD's
- ☐ Drug/Alcohol abuse
- ☐ Frequent colds/flu
- ☐ Bronchitis
- ☐ Other _____

For women only

Are you:

- ☐ Pregnant
- ☐ Nursing
- ☐ Planing to get pregnant

Color of flow:

- ☐ Dark red
- ☐ Bright red
- ☐ Heavy bleeding
- ☐ Light bleeding

Are there clots? ☐yes ☐ no

Date of last period _____

No. of days of flow_____

Check symptoms that you experience related to Menses

- ☐ Cramping
- ☐ Burning feeling
- ☐ Dull aches
- ☐ Stabbing pain
- ☐ Bloating
- ☐ Bearing down sensation
- ☐ Hot flashes
- ☐ Mood swings
- ☐ Headache
- ☐ Swollen breasts
- ☐ Poor appetite
- ☐ Increase/Decrease libido
- ☐ Night sweats
- ☐ Insomnia
- ☐ Diarrhea
- ☐ Other_____

Nutrition/Diet

Please describe how you eat

□ Balanced diet of natural foods and processed fords, including fruits, vegetables, meat, dairy and grains.
□ Vegetarian (if yes, how long?) _____
□ Vegan (if yes, how long?) _____
□ Heaviest on meat (i.e. red meat more than 3 days a week)
□ Heaviest on pastas, breads and cereals □ whole grain OR □ processed
□ Heaviest on sweets
□ Heaviest on salty snacks

Coffee _____cups per day
Soda and sweet drinks _____ per Tag □ Diet □ Sugared
Microwaved food _____ times a week
Do you smoke? □ Yes □ No If yes, how many cigarettes a day? _____
Alcohol use? □ Light □ Moderate □ Heavy

How is your sleep?

Do you usually get to sleep within 20 minutes of retiring?	□ yes	□ no
Do you often (3 or more times a week) wake up in the middle of the night?	□ yes	□ no
If so, is urinary urgency the main factor in waking up?	□ yes	□ no
Do you get back to sleep easily?	□ yes	□ no
Do you feel refreshed after a typical night of sleep?	□ yes	□ no

If you awaken in the night, what time is it usually? _____
How many hours of sleep do you typically get? _____hours
Do you experience any pain at night that wakes you up? _____
Do you experience an energy drop at a regular time of day? _____
Any additional comments? _____
_____
_____

Please mark as follows: Sometimes experience check □S; Frequently experience check □F

Earth
□S □F Appetite –too high, too low
□S □F Tiredness
□S □F Loose stools
□S □F Constipation
□S □F Chronic sinus infections
□S □F Indigestion/heartburn/reflux
□S □F Bloating/gas after eating
□S □F Belching, vomiting, nausea, pain
□S □F Mental fatigue- fogginess
□S □F Weak limbs- lack of flexibility
□S □F Undigested food in stool
□S □F A feeling of retention of food in the stomach
□S □F Bleeding gums
□S □F Bruise easily
□S □F Cold limbs
□S □F Tendency to become obsessive
□S □F Worry too much

Wood/Tree
□S □F Pain (general body pain)
□S □F Sighing (do you notice yourself sighing)
□S □F Depression
□S □F Numbness in extremities
□S □F Tics or tremors
□S □F Dizziness
□S □F Anaemia
□S □F Eyes (blurred, floaters, dry, red?)
□S □F Dry skin/hair, brittle nails
□S □F Chronic stiff neck/joints,
□S □F PMS (any related issues)
□S □F Headaches
□S □F Diarrhea
□S □F Flashes of anger
□S □F Bitter taste in the mouth

Fire
□S □F Insomnia, difficulty sleeping
□S □F Heart palpitations
□S □F Anxiety
□S □F Dizziness
□S □F Dream disturbed sleep
□S □F Easily startled
□S □F Blood clots
□S □F Mental confusion
□S □F Cold limbs
□S □F Feeling of heaviness in chest
□S □F Pain radiating down the left arm
□S □F Uncontrollable laughter or crying
□S □F Spontaneous sweating

Water
□S □F Asthma
□S □F Cold limbs
□S □F Excess urination
□S □F History of urinary tract infections
□S □F Incontinence
□S □F Tinnitus, ringing in ear
□S □F Night sweats
□S □F Sore or weak back
□S □F Sore or weak knees
□S □F Edema
□S □F Aversion to cold
□S □F Low libido/Sexual dysfunction

Small fire
□S □F Swollen lymph nodes
□S □F Nervous in social situations
□S □F Tonsilitis
□S □F Allergies
□S □F High blood pressure
□S □F Low blood pressure
□S □F Sensitive skin
□S □F Rashes
□S □F Hives

Emotions/Attitude
□S □F Happy, joyful
□S □F Gratitude
□S □F Irritability
□S □F Anger
□S □F Anxiety
□S □F Fulfilled life
□S □F Sadness
□S □F Fearful
□S □F Easily stressed
□S □F Depression
□S □F Grief
□S □F Seeing a therapist

Metal
□S □F Chronic cough
□S □F Shortness of breath
□S □F Asthma
□S □F Weak voice
□S □F Dry throat, hoarseness, dry cough
□S □F Daytime sweating
□S □F Night-time sweating
□S □F Skin problems, eczema, psoriasis
□S □F Toothaches

Favorite Season
□S □F Winter
□S □F Spring
□S □F Summer
□S □F Late Summer
□S □F Autumn

Shiatsu is therapeutic massage and should not be construed as a substitution for medical examination, diagnosis, or treatment. Qualified medical professionals should be consulted for conditions that are beyond the scope of shiatsu and therapeutic massage.

Shiatsu is also contraindicated under certain conditions thereby making it important that all known medical conditions are shared with the therapist. Please update me on any changes in your medical profile.

This information is confidential and will only be used to develop the best possible treatment plan for your needs/pattern. If following your treatments, you think of other symptoms or information that may be relevant to your health patterns, please let me know. Thank you.