Kristin Burns, LCSW, AOBTA CP, RMT
Mind Body Therapist

Zen Shiatsu Intake Form

Thank you for choosing me to help you regain balance, energy, and living life to the fullest. Please take your time with this intake. No matter how we work together, the information you provide assists me to decide where and how we work together to meet your needs so you can feel better, live happier. Even if you are just looking for a pleasant bodywork session and not concerned with any particular health issues, please take the time to complete all information.

Name: _____
Address: _____
City: _____
State/ ZIP:_____
Phone: _____
Email: _____
Date of birth:_____
Name of current Medical Professional:
_____
What type of work do you do?
_____
How many hours per week?
_____
Do you enjoy your work?
_____
Please circle:

Single Married Life Partner Separated Divorced

Have you ever had a Shiatsu session before? Yes No

Emergency Contact:
Name:_____
Phone:_____

Current Condition/Briefly tell me, what would you like help with today?

_____
_____
_____
_____

On a scale of 1 -3, or low, medium, high, to what extent does the problem(s) interfere with your daily activities?

_____
_____

Have you ever been given a diagnosis for this problem(s)? If so, what diagnosis and by whom?

_____
_____

What has been prescribed, or suggested?
What has helped?

_____
_____
_____
_____

What medications, (drugs, herbs, oils, over the counter medications, vitamins) are you currently taking?

_____
_____
_____

Self care is important -are there any daily practices you currently and consistently do that help you feel better? If so please list them.

_____
_____

_____

_____

Please list any areas that are recently injured
Recent surgery, deep bruising, varicose veins, or ticklish:

_____

_____

_____

_____

_____

Please list any significant physical trauma

(auto accidents, injuries, surgeries, work related injury, stress, physical abuse), etc
Dates:_____

_____

Describe:

_____

_____

_____

_____

_____

Significant emotional trauma

(divorce, deaths, difficult changes)
Dates: _____
Describe:_____

_____

_____

Personal Health History

Please check all that apply:

o Cancer
o Diabetes
o Hepatitis
o High Blood Pressure
o Asthma
o Allergies
o Heart Disease

o Rheumatic Fever
o Thyroid Disease
o Seizures
o Pneumonia
o AIDS/HIV
o Herpes
o Chlamydia
o Other STD

o Drug/Alcohol Abuse
o Frequent Colds/Flu
o Bronchitis
o Other
_____
_____
_____

FOR WOMEN:

Are you:

o pregnant
o Currently nursing
o Planning to become pregnant
o In peri menopause?
o In menopause?

Check symptoms you experience related to Menses

o Cramping
o Burning feeling
o Dull aches
o Stabbing pain
o Bloating
o Bearing down sensation
o Hot flashes
o Mood swings

o Headache
o Swollen breasts
o Poor appetite
o Increase/decrease libido
o Night sweats
o Insomnia
o Diarrhea
o Other _____

Diet

Please describe your diet

What foods do you eat the most of? And, is there anything you CRAVE? Do you smoke cigarettes?

_____

_____

o Coffee
Cups per day: _____
o Soda per day: _____
o Alcohol:
o Light
o Moderate
o Heavy
Good nutrition is so important to your health, is there anything else about food you want to mention or want help with?

_____
_____
_____
_____

How is your sleep?
Do you usually get to sleep within 20 minutes of retiring?
o Yes o No
Do you often wake up in the middle of the night?
(3x week or more)
o Yes o No
If so, is urinary urgency the main factor in waking up?
o Yes o No
Do you get back to sleep easily?
o Yes o No
Do you feel refreshed after a typical night of sleep?
o Yes o No
How many hours of sleep do you typically get?
_____hrs.
Do you experience any pain at night that wakes you up?
_____
Do you experience an energy drop at a regular time of day?
_____
If sleep is an issue for you? _____

Rate your stress level here :
___low ___med ____high

ST/SP:

__ Digestive issues
__ stomach
__ bowel
__ Loose stools or constipation
__ Chronic sinus issues, infection, nasal drip
__ Weakness in muscles, limbs
__ Mental fatigue
__ foggy/heavy head
__ Hold extra weight easily
__ Crave sweets
__ Bleeding gums
__ Bruise easily
__ Cold Limbs
__ Over think/over worry
__ Indecisive
__ Overly involved in taking care of others
__ Sensitive to criticism
__ Often disappointe

LV/GB:

__ Pain in joint/connective tissue
__ PMS
__ Hemorrhoids
__varicose veins
__ Anemia
__ Headaches
__ Neck and shoulder tension
__ Tics or tremors
__ Bitter or metal taste in mouth
__ Sighing (do you notice yourself sighing)?
__ Eyes __ blurred __ floaters __ dry__ red?
__ Dry skin/hair
__ brittle nails
__ Depression
__ prone to:
__ Anger, frustration, irritable
__ When stressed - blow or burst in anger
__ Lack motivation

HT/SI:

__ Insomnia, difficulty sleeping
__ Heart palpations / heart issues history
__ Dizziness
__ Cold limbs
__ poor circulation
__ High or low blood pressure
__ Dream disturbed sleep
__ Feel heat in the face, head, flushed
__ Pale face

__ Anxious, agitation, restless, jumpy
__ Overly emotional /sensitive
__ Poor memory, forgetful, scattered
__ Compulsive behaviors
__ Disconnected, socially uncomfortable
__ Uncontrollable, inappropriate laughter or crying

KI/UB:

__ Low back issues
__ weak, pain, chronic
__ Knees: sore or weak
__ Cold limbs
__ Urinary problems
__ current or history of:
__ Tinnitus
__ ringing in ear
__ Dark circles under eyes
__ Night sweats
__ Edema

__ Aversion or sensitive to cold
__ Weak bones, teeth
__ Low Libido/ Sexual dysfunction
__ Overly fearful, dislikes change
__ Strong fear of failure
__ Feel insecure, tend to withdraw, or timid
__ No fear
__ reckless behaviors

LU/LI:

__ Prone to respiratory issues
__ Asthma
__ Experience shortness of breath easily
__ Sensitive skin, dry, eczema/psoriasis
__ Rashes
__ Hives
__ Halitosis – bad breath
__ Perfectionist type
__ Deep feelings of sorrow, sadness, grief
__ Withdrawn, distant
__ Feel powerless
__ Rigid thinker

At times, I may use Aromatherapy.
Any known allergies to plants?

_____

_____

Do you have a favorite oil/aroma?

_____

Do you have an oil/aroma you don't want used?

_____