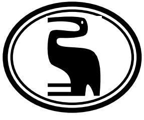


Burnsville Shiatsu Center ---------------- Health Questionnaire

Welcome to Shiatsu! The following questionnaire assists us in gathering information about energy patterns in your body, so we can custom design your treatment All of your answers are strictly confidential.
Thank You !

PERSONAL INFORMATION

Name____ Date________________

Address____City___________________________

State____________ Zip_________ Work Phone_________________ Home Phone_________________

Cell Phone _______________________ Email Address: ____________________________________

Date of Birth __________ Height ______ Weight ______

Occcupation____

Spouse/Partner's Name _____________________ # of Children ____ Ages _________

Have you ever had a Shiatsu before? If so, when and where?____

Where did you hear about the Burnsville Shiatsu center? ____________________________________

CURRENT CONDITION

Reason for visit today____

How long have you had this condition? ____

Is it getting worse? __________ Does it bother your: Sleep ?______ Work ?_______ Other?_____________

What seems to be the initial cause? ____

What seems to make it better?____

What seems to make it worse?____

Are you under the care of a licensed health care professional now? ____Yes ____No If yes, what is the diagnosis?

____

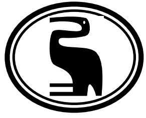
Licensed health care professional?____

What other kinds of treatment have you tried or are you trying?____________________________________

Medical History

Check any of the following conditions you currently have. Double-check those that are in the past.)

☐☐ Chronic Disease (Diabetes, Epilepsy) Etc.)	☐☐Fibromyalgia ☐☐Cancer ☐☐Headaches/Migraines ☐☐ Liver Disease	☐☐Physical Traumas (Car accidents, falls, etc.)	☐☐Surgery (list) ____________	☐☐Emotional Traumas (Abuse, death in family, etc)
______________	________________	______________	____________	______________
______________		______________	____________	______________



Your Diet

Appetite	☐ ☐Low	*Thirst for Water*	☐ ☐Low	***Cravings***	☐ ☐Sugar
	☐ ☐High		☐ ☐High		☐ ☐Salty Food

Please list any of the following supplements that you are taking - Pharmaceuticals, Vitamins, Herbs, Others?

____

____

Your Lifestyle - Please note amount and/or frequency (1x day, 1x week, 1x month, etc.)

☐Alcohol _____________	☐Stress__________________________	☐Coffee ____________________
☐Tobacco_____________	☐Occupational Hazards_____________	☐Artificial Sweeteners_________
☐Regular Exercise _____________		☐Soft Drinks __________________

General Symptoms

☐Dream-disturbed sleep	☐Poor Sleep	☐Bodily heaviness	☐Chills	☐Bleed or bruise easily
☐Cold hands or feet	☐Heavy Sleep	☐Lack of strength	☐Night sweats	☐Peculiar Taste
☐Strongly like cold drinks	☐Poor appetite	☐Poor circulation	☐Sweat easily	(describe)___________
☐Strongly like hot drinks	☐Heavy appetite	☐Shortness of breath	☐Muscle Cramps	___________________
☐Recent weight loss/gain	☐Fatigue	☐Vertigo or dizziness	☐Fever	___________________

Head, Eyes, Ears, Nose, Throat

☐Glasses	☐Night blindness	☐Sores on lips or tongue	☐Recurrent sore throat	☐Headaches
☐Eye strain	☐Glaucoma	☐Dry mouth	☐Swollen glands	☐Concussion
☐Eye pain	☐Cataracts	☐Excessive saliva	☐Lumps in throat	
☐Red eyes	☐Teeth pain	☐Sinus Problems	☐Enlarged thyroid	Other head or neck problems
☐Itchy eyes	☐Grinding teeth	☐Excessive Phlegm	☐Nose Bleeds	___________________
☐Spots in eyes	☐TMJ	Color of phlegm	☐Ringing in ears	___________________
☐Poor vision	☐Facial pain	___________________	☐Poor hearing	___________________
☐Blurred vision	☐Gum problems	☐Earaches		___________________

Respiratory

☐Difficulty breathing	☐Shortness of breath	☐Tight Chest	☐Cough
☐Asthma	☐Sinus Infection		

Cardiovascular

☐Heart palpitations	☐Irregular heartbeat	☐Blood clots	☐ Fainting

Gastrointestinal

☐Nausea	☐Constipation	☐Intestinal pain or cramping	Frequency of Bowel Movements:
☐Vomiting	☐Laxative use	☐Bloating	______________________________
☐Gas	☐Diarrhea	☐Bad breath	Any irregularities:
☐Hiccups	☐Supplemental Fiber	☐Acid regurgitation	________________________________

Skin and Hair

☐Rashes ☐Eczema ☐Dandruff ☐Change in hair/skin texture ☐Other hair or skin problems (describe)
☐Hives ☐Psoriasis ☐Itching ☐Fungal infections ____________________
☐Ulcerations ☐Acne ☐Hair Loss ____________________

Neuropsychological

☐Poor memory ☐Irritability ☐Anxiety Other (specify)
☐Numbness ☐Depression ☐☐Seeing a therapist ____________________

Genito-urinary

☐Pain on urination ☐Kidney stone ☐Wake to urinate
☐Frequent urination ☐Unable to hold urine ☐Urgent urination

Gynecology

Age menses began: ____________________
Length of cycle: ____________________
Duration of Flow: ____________________

☐Irregular periods
☐Painful periods
☐PMS

☐Currently Pregnant
Pregnancies #__________

Age at menopause
____

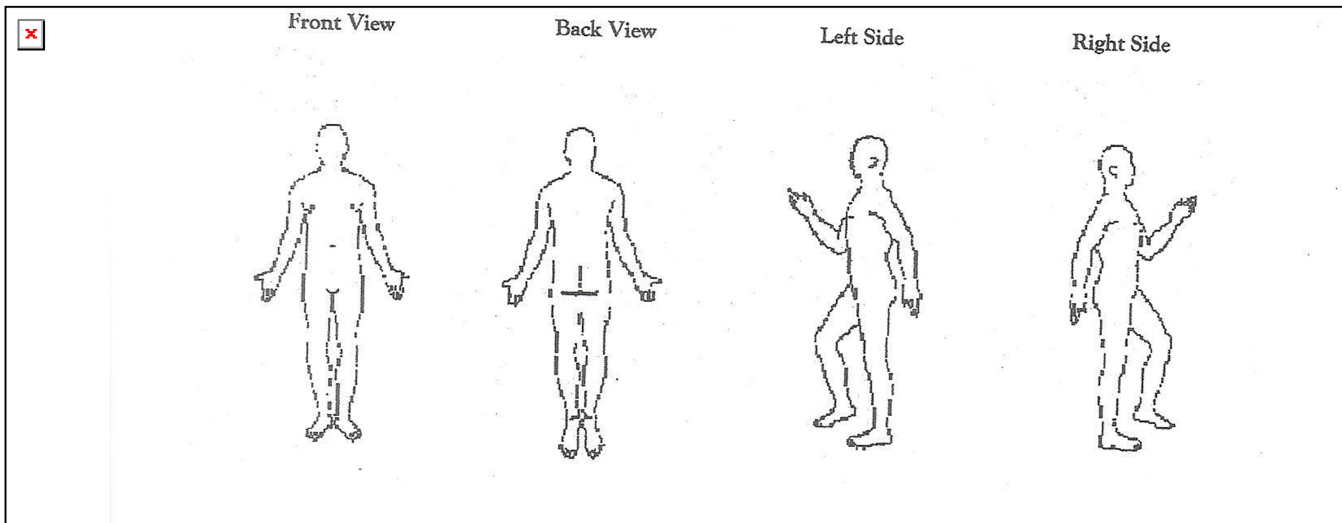
Musculoskeletal

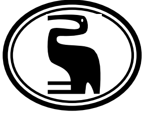
☐Neck/shoulder pain ☐Upper back pain ☐Joint pain ☐Limited range of motion Other (describe)
☐Muscle pain ☐Lower back pain ☐Rib pain ☐Limited use ____________________

Other

____
____
____

Please mark these drawings according to where you are experiencing specific pain.





Complementary & Alternative Health Care Client Bill of Rights

Please refer to "Our Therapists" link to see the therapists bio

12400 Pillsbury Avenue S., Burnsville, MN 55337 Telephone number: 952-882-7933

As of July 1, 2001, Minnesota's Freedom of Access to Complementary Care Law (Statute Chapter 146A) requires that you receive and acknowledge that you have received by your signature on this page, the following information prior to your treatment. (Therapist), hereafter, "the Practitioner" has the received following education, training & credentials: **Graduate of the Minnesota Center for Shiatsu Study (now CenterPointe) – AOBTA and State of MN approved Professional Training Program for Asian bodywork therapy and Traditional Chinese Medicine; Shiatsu Practitioner certified by the American Organization for Bodywork Therapies of Asia (AOBTA), the national professional association for Asian bodywork.**

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

- **Complaints:** If the Client has a complaint or concern about the care or services they have received, the Client may also contact the Office of Unlicensed Complementary and Alternative Health Care Practice located in Minnesota Department of Health: **Mailing address:** P.O. Box 64882, St. Paul, MN 55164-0882
  Phone: 651-201-3721 **TTY:** 651-201-5797 **Fax:** 651-201-3839
  Website: http://www.health.state.mn.us/divs/hpsc/hop/ocap/index.html

Fees and Services (sales tax included) $69 for an hour session $43 for a half hour session

Packages: $192 for 3 one hour sessions $301 for 5 one hour sessions $188 for 5 half hour sessions

Check, cash, and credit cards accepted. Fees are payable in full at the end of each session. Clients have the right to reasonable notice of changes in services or fees. If you are unable to attend a scheduled session, you agree to provide 24 hour notice to the practitioner whenever possible. The practitioner may charge up to the full session fee for no-shows or sessions canceled without sufficient notice.

Theory of Treatment: Shiatsu Anma is Japanese bodywork with a foundation in Traditional Chinese Medicine. Shiatsu uses a combination of finger pressure along with kneading, stretching, and percussive techniques. Performed through clothing, with the goal of restoring, maintaining and optimizing the physical, mental and spiritual well-being of the client, shiatsu promotes and balances the flow of Qi, the body's vital energy.

- **Right to Current Information:** Clients have the right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.
- **Right to Confidentiality:** Client records are confidential and will not be released, unless authorized by the client in writing or as otherwise provided for by law.
- **Right to Self Access:** Clients have the right to access to their own records maintained by the Practitioner's office, in accordance with state statute sections 144.291 to 144.298;
- **Personal Interaction:** Clients have the right to expect courteous treatment, free from verbal, physical, or sexual abuse.
- **Other Treatment Available:** Other massage therapy services are available to the Client in this same community. These can be located by asking the Practitioner, the provider who referred you to this practitioner or the following practitioner database: www.amtamassage.org
- **Right of Agency:** The Client has the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs
- **Records Transfer:** The Client have the right to coordinated transfer of your records when there will be a change in the provider of services
- **Right of Refusal:** The Client may refuse services or treatment, unless otherwise provided by law.
- **Right of Nonretribution:** The Client has the right to assert the any and all of above-mentioned rights without retaliation from the Practitioner.

I ______________________________acknowledge by my signature that I have received and understand the Complementary and Alternative Health Care Client Bill of Rights.

Signature____Date_________