



Today's Date: _____

For Office Use: *Le Shiatsu's* ID: _____

CONSENT TO TREATMENT

We hope you will enjoy your Shiatsu experience!

Thank you for taking a few moments with this form and to fill it before your first Shiatsu treatment.

Name (First, Last): _____	Date of Birth (YYYY-MM-DD): _____
Address: _____	Home Phone: _____ Daytime phone: _____
Occupation: _____	Language: English <input type="checkbox"/> French <input type="checkbox"/>
Doctor (Name, city): _____	Telephone # and name of emergency contact (e.g. spouse etc): _____
Email: _____	May we send messages / newsletters: Y <input type="checkbox"/> N <input type="checkbox"/>

Shiatsu is practiced through clothing by applying gentle finger pressure and comfortable stretches. Shiatsu leverages the principles of acupuncture, however no needle is used. Usually treatments are on the whole body. Different parts of the body can be treated, in order to release tensions and promote free flow of Chi energy.

Is there any area of your body that you do not want touched? Yes No

If yes, please specify:

Please indicate if any of the following applies to your situation:

- | | |
|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Bruising easily | Y <input type="checkbox"/> N <input type="checkbox"/> Infectious disease (incl. flu etc: you might be contagious to others) |
| Y <input type="checkbox"/> N <input type="checkbox"/> Brittle bones or osteoporosis | Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes |
| Y <input type="checkbox"/> N <input type="checkbox"/> High, or low blood pressure | Y <input type="checkbox"/> N <input type="checkbox"/> Cancer |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart condition, heart rhythm trouble, venous or circulation issue | Y <input type="checkbox"/> N <input type="checkbox"/> Other condition: _____ |

Is there anything that the therapist might not be able to see or that might be hidden by your clothing: e.g. open wound, recent scar, broken skin or skin issue, varicose vein, nodule, tumor, etc...

Y N

For women: Is there any chance that you may be pregnant? Y N

I have had the opportunity to ask questions about this confidential form and about Shiatsu therapy, and I understand the nature of Shiatsu therapy.

I understand that my record or any information within my record is confidential. It will not be released to anyone unless: I give explicit consent; or if directed by law.

I understand that open communication with the therapist is welcome and appreciated, and that I may change or stop the course of treatment at any time. By my consenting to treatment, I will not hold the Shiatsu therapist personally liable for any ill effect or injury, incurred before, during, or after the course of the treatment. I also release the Roberts Centre of Integrative Medicine Inc. (its owners, employees and contractors) from any claims, demands and causes of action arising from my voluntary participations in the Centre's Shiatsu services.

I have been informed about the charges that apply.

This consent is signed before the first treatment begins. It applies to the entire course of treatment for my condition and for future conditions for which I seek treatment.

Name: _____ Signature: _____ Date : _____

Therapist's Signature: _____



INITIAL INTAKE FORM

Have you had Shiatsu treatment(s) before: Y N If yes, who was your therapist: _____

Have you had a history of or are currently experiencing health problems in any of the following areas:

Muscles, skin:	Allergies:
Bones, joints:	Respiratory :
Heart, circulation, blood pressure:	Under / Over active thyroid: Other hormonal:
Neurologic issues:	Headaches / migraine:
Tumors, lumps:	Diabetes:
Spinal injuries, back or disc problems:	Urinary, reproductive:
Infectious disease:	Elimination, bowel:
Mental, emotional:	Insomnia, sleep issues:
Other: Or are you currently experiencing symptoms that may have not been listed above or medically diagnosed:	

Please list all surgeries, trauma or injuries you have had and indicate the year

Surgery and condition for which it was performed, or trauma / injury (e.g. car accidents, falls):	Year:

Please list all the medications you are taking, including supplements or herbal remedies.

Medication	Condition it treats	Since when

Family History: Please indicate which conditions and which family member (e.g. sibling, parent etc)

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Do you exercise?: Cardio <input type="checkbox"/> Strength Training <input type="checkbox"/> Flexibility <input type="checkbox"/> How frequently? _____	Are you on a specific diet? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please specify: _____ Are you trying to loose <input type="checkbox"/> , or gain <input type="checkbox"/> weight?
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For women: Is there any chance you may be pregnant: Y N When was your last period: _____

Are you taking oral contraception or hormonal replacement therapy? Y N Have you in the past: _____

Number of days between 2 periods: _____ Is it regular: Y N Is the flow: heavy light normal

Number of days a period lasts: _____ Color: bright red red dark / purple Do you have clots: Y N

Do you have cramps with your period: no mild moderate severe Do have nausea: Y N

Do you have back pain: Y N Breast tenderness: Y N Headaches: Y N

PMS: A few days or just before your period, do you experience: mood changes / irritability / depression

headaches breast tenderness Other: _____

Do you experience between periods: abnormal vaginal discharge bleeding painful intercourse

Do you have breast lumps: Y N

If you are in your menopause: Do you get: hot flashes Night sweats Mood swings Headaches

Concentration or memory difficulties Insomnia Weight gain Cravings