NEW PATIENT SHIATSU INTAKE FORM

| Name |
|--|
| Address |
| City State Zip |
| Date of Birth email |
| tel # dayevening |
| Occupation |
| Physician Referred by |
| What is the main problem that brought you to seek shiatsu? |
| |
| |
| |
| Have you ever had surgery? Yes No |
| If yes, please describe |
| Have you recently suffered an acute injury? Yes No |
| If yes, please describe |
| Do you have any spinal injuries? Yes No |
| If yes, please describe |
| Do you have any skin problems? Yes No |
| Do you have varicose veins of blood clots? Yes No |
| Do you have arthritis? Yes No |
| Do you have heart problems or high blood pressure? Yes No |
| Do you take prescription medications? Yes No |
| If yes, please describe |

| Do you exercise regularly? Yes No |
|---|
| If yes, please describe |
| Briefly describe your diet: |
| How would you rate your energy? low 1 2 3 4 5 6 7 8 9 10 high |
| Are you pregnant? |
| Is your menstrual flow regular |
| Do you have any areas that need special attention? |
| Is there anything else I should be aware of? |
| AGREEMENT |
| I, understand that Shiatsu therapy given |
| here is for the purpose of stress reduction and for increasing circulation and energy flow. I |
| understand that Deana Darby does not prescribe medical treatment of pharmaceuticals, nor |
| does she perform and spinal or tissue manipulations. Its been made very clear to me that |
| Shiatsu is not a substitute for medical examination and or diagnosis. |
| Because, Deana Darby must be aware of existing physical conditions, I have stated all my |
| known medical conditions and take it upon myself to keep her updated on my physical health |
| Signature Date |

CANCELLATION POLICY

I understand that I am financially responsible for all scheduled appointments and agree to pay in full for any appointments that are not cancelled within 24 hours of the scheduled time. To cancel please email Deana Darby directly at ddarby108@gmail.com or call her on her cell phone 603-809-3396.

Thank you!