Kaizen Healing Arts

The art of harmonious living through Asian bodywork

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Health History Form for Bodywork

Name/DOB ____
First *Last* *Date of Birth*

Address ____
Street

____
City *State* *Zip Code*

Phone Number ______________________ Email ______________________

Occupation ____

Emergency Contact ______________________ Phone Number ______________________

How did you hear about us? ____

Have you experienced professional mat-based bodywork (including Thai massage/Shiatsu, etc.?) Y ☐ N ☐

How often? ____________ Areas to Avoid? ____________ Preferred Pressure? ____________

Please describe your reason for this visit, including
any current complaints and areas of tension or discomfort. ______________________________

____

Please check all of the following conditions that currently apply to you:

Acute Infection	☐	Acute Injury	☐	Allergies	☐
Anxiety	☐	Arthritis	☐	Autoimmune Disorder	☐
Athlete's Foot	☐	Bruising/Bruise Easily	☐	Cancer	☐
Cold/Flu	☐	Chronic Back Pain	☐	Depression	☐
Diabetes	☐	Digestive Concerns	☐	Dizziness	☐
Edema	☐	Epilepsy/Seizures/Convulsions	☐	Fatigue	☐
Fever	☐	Fibromyalgia	☐	Headaches	☐
Heart Condition	☐	Herniated Disc	☐	High Blood Pressure	☐
Infectious Condition	☐	Insomnia	☐	Loss of Range of Motion	☐
Muscle Spasms	☐	Muscle Tension	☐	Numbness or Tingling	☐
Osteoporosis	☐	Pain	☐	Phlebitis/Thrombosis	☐
Pregnancy	☐	Skin Condition/Rash	☐	Stiff Neck/Shoulders	☐
TMJ Dysfunction	☐	Varicose Veins	☐		

THE FIVE TRANSFORMATIONS

Please share your experience/concerns.

	METAL	WATER	WOOD	FIRE	EARTH
	Grief	Fear	Anger	Joy/Sadness	Worry
Emotions ✓ *for frequent or intense*	☐	☐	☐	☐	☐
	Skin	Bones	Tendons	Blood Vessels	Muscles
Body Tissues ✓ *for an area of concern*	☐	☐	☐	☐	☐
	Nose	Ears	Eyes	Tongue	Mouth
Senses ✓ *for an area of concern*	☐	☐	☐	☐	☐
	Sharp/Pungent	Salty	Sour	Bitter	Sweet
Tastes ✓ *for like*	☐	☐	☐	☐	☐
	Dry	Cold	Wind	Heat	Damp
Climates ✓ *for like*	☐	☐	☐	☐	☐
	Lungs	Kidneys	Liver	Heart	Spleen
Yin Organs ✓ *for an area of concern*	☐	☐	☐	☐	☐
	Lg. Intestine	Bladder	Gall Bladder	Sm. Intestine	Stomach
Yang Organs ✓ *for an area of concern*	☐	☐	☐	☐	☐

THE FOUR PILLARS OF HEALTH

Please share your behaviors.

Nutrition ____________________

Exercise ____________________

Sleep ____________________

Meditation ____________________

CONDITIONS

Please share your experiences, past and present, and dates.

Illnesses and diseases ______________________

Injuries, traumas and surgeries ______________________

Current medications & supplements ______________________

Significant emotional events ______________________

Please take a moment to read the following and sign below.

I understand that the massage/bodywork I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical treatment. I understand that massage/bodywork practitioners are not qualified to diagnose, prescribe or treat physical or mental illness and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I understand that if I cancel an appointment within 24 hours of the scheduled appointment time, I am responsible for full payment.

I understand that my information will be kept confidential and only released with my permission.

Client ______________________ *Date* ______________

Practitioner ______________________ *Date* ______________