

## Initial treatment form

Name of receiver:	Date of treatment:
Address	
Tel numbers:	

DOB:
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Main reason(s) for seeking shiatsu treatment:
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Major injuries:

Major illnesses:

Surgical history:

Current medical or other treatment including medication or supplement use:

Receiver's description of their general energy and whether it fluctuates (during day or seasonally):

Sleep pattern:

<b>Details of diet</b>	
Meat	
Vegetables	
Spicy foods	
Dairy	
Fats	
Fruit	
Carbohydrates	
Salt	
Packaged food	
Sugar	
Taste	
Sugary	
Craving	
Regularity of meals	
Coffee	
Tea	
Alcohol	

Smoker	
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Exercise:
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Healthcare checks:		

Bowels:	
Frequency:	
Constipation:	
Diarrhoea	
Any changes/concerns:	

Urine:	
Quantity (copious/scant):	
Colour:	
Any changes/concerns:	

Menstrual cycle (eg frequency/heaviness):	
Pregnancies:	
Any changes/concerns:	

Any other information:

<b>Posture assessment:</b> 	<b>Face diagnosis:</b> 	<b>Tongue diagnosis:</b> 
	<b>Five Element:</b>	
	<b>Voice:</b>	<b>Smell:</b>
<b>Skin Hue:</b>		<b>Colour of Clothes:</b>
<b>Other:</b>		