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# **Treatment Record Form**

**Client Name**:

Shiatsu Treatment: seated / lying down

Event Location: Date:

Practitioner Name:

**Client’s relevant medical history**

|  |  |
| --- | --- |
| **Please give details if you have experienced any of the following:** | **Please give details including dates/frequency where relevant** |
| Recent surgery |  |
| Problems with head, neck, shoulders |  |
| Increase in stress |  |
| Movement restrictions (arthritis/spondylitis etc) |  |
| Blood pressure (high/low) |  |
| Varicose veins |  |
| Cardiac problems/ heart disease |  |
| Stroke |  |
| Headaches/migraine |  |
| History of dizziness/fainting |  |
| Epilepsy |  |
| Diabetes |  |
| Incidence of cancer/lumps |  |
| Neurological problems/numbness/tingling |  |
| Injuries/whiplash: |  |
| TMJ (Temperomandibular Joint) problems |  |
| Osteoporosis |  |
| Chest or respiratory problems (asthma etc) |  |
| HIV infection |  |
| Hep B infection |  |
| Cellulitis |  |
| Eczema |  |
| Impetigo |  |
| Psoriasis |  |
| Fatigue |  |
| Pregnant Y/N |  |
| Other condition not above |  |
| Medication being taken |  |

**I CONFIRM I HAVE PROVIDED ALL RELEVANT MEDICAL INFORMATION.**

**I understand Shiatsu is not a substitute for medical treatment.**

|  |  |
| --- | --- |
| I consent to treatment: Date:  Signed by client (or parent/guardian): | |
| I understand that the information given above will be stored confidentially and will not be shared with any other party unless with my permission. | Tick to agree: |
| Signed: | Date: |

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The National Network for information on Shiatsu and the Professional Practitioners Association

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