Serene Body Therapy

Name ______________________________ Day Phone # ____________ (H/W/C)

Address ______________________________ Eve Phone # ____________ (H/W/C)

City ______________________ State ________ Zip code ____________

Email ______________________________ Date of Birth ________

Emergency Contact ______________ Phone # ______________ Your Profession ______________

Current Health Care Professional ______________________________

Have you ever had? _____ Acupuncture _____ Massage _____ Shiatsu _____ Reflexology

If yes, where and when ______________________________

How did you hear about me? ______________________________

Current Condition

Main problem(s) you would like helped with today ______________________________

____

How long ago did the problem(s) begin – be specific ______________________________

____

To what extent does the problem(s) interfere with your daily activities? ______________________________

____

What kinds of treatments have you tried? ______________________________

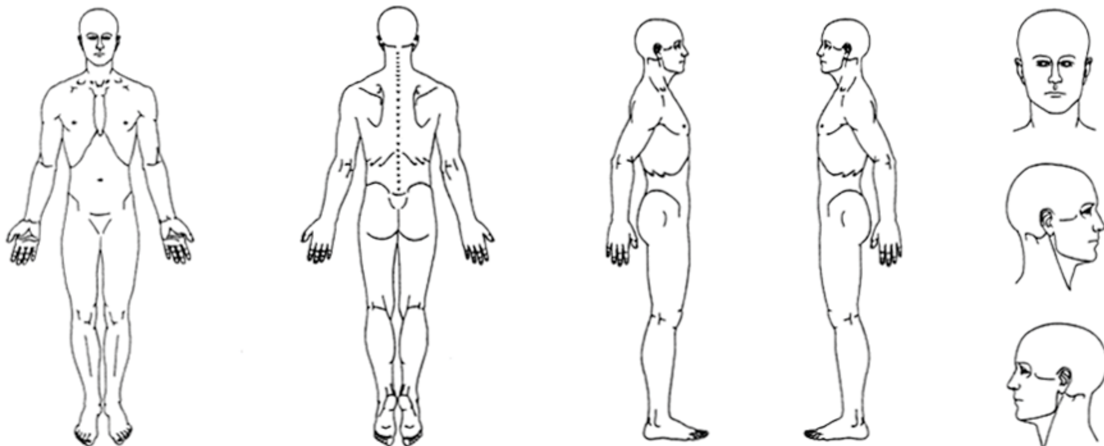
____

What medications (drugs, herbs, vitamins, ect.) are you currently taking? ______________________________

____

Do you wear contact lenses or dentures? . . . . yes no
Are you sensitive to perfumes, lotions, or oils? . . . . yes no
Do you exercise regularly or participate in any sports? . . . . yes no
Do you have any skin problems or allergies? . . . . yes no
Do you have any heart problems? . . . . yes no
Do you have high blood pressure? . . . . yes no
Do you have varicose veins or blood clots? . . . . yes no
Do you have arthritis, osteoporosis, brittle bones, or spinal problems? . . . . yes no
Do you have any lung or breathing problems? . . . . yes no
Do you have digestive tract problems? . . . . yes no
Are you pregnant? . . . . yes no
Have you suffered any acute injuries, illnesses or been hospitalized in the last year? . . . . yes no

Mark any areas of tension or soreness you would like the therapist to address on figures below



Please Check All That Apply

GENERAL

- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ Fatigue
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Tremors
- ☐ Bleed/Bruise easily
- ☐ Weight loss
- ☐ Weight Gain
- ☐ Edema
- ☐ Dislike heat
- ☐ Reduces sexual energy
- ☐ Varicose veins
- ☐ Prefer cold drinks
- ☐ Prefer hot drinks
- ☐ Sudden energy drop
- ☐ Time of day ____________

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Muscle weakness
- ☐ Swollen joints
- ☐ Numbness

RESPIRATORY

- ☐ Chest pains
- ☐ Distension in chest
- ☐ Shallow breathing
- ☐ Cough
- ☐ Cough up blood
- ☐ Phlegm
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Emphysema
- ☐ Pleurisy
- ☐ Pneumonia

URINATION

- ☐ Frequent urination
- ☐ Wake up to urinate
- ☐ Pain when urinating
- ☐ Decrease in urination
- ☐ Blood in urine
- ☐ Dark colored urine
- ☐ Clear urine
- ☐ Cloudy Urine
- ☐ Decreased bladder control

CARDIOVASCULAR

- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Hot hands and feet
- ☐ Stroke
- ☐ Heart Attack

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Epilepsy
- ☐ Tremors

EMOTIONAL

- ☐ Depression
- ☐ Anxiety
- ☐ Irritable
- ☐ Indecisive
- ☐ Fearful
- ☐ Easily Stressed
- ☐ Cannot shut off mind
- ☐ Frequent crying
- ☐ Mood Swings

HEAD AND EYES

- ☐ Glasses/Contacts
- ☐ Poor vision
- ☐ Night Blindness
- ☐ Color blindness
- ☐ Blurry vision
- ☐ Eye strain
- ☐ Dry eyes
- ☐ Migraines
- ☐ Headaches
- ☐ Floaters
- ☐ Red/Itchy Eyes
- ☐ Dark circles under eyes

EARS, NOSE, THROAT

- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Grinding teeth
- ☐ Jaw clicks
- ☐ Dry mouth and throat
- ☐ TMJ Problems
- ☐ Feeling of lump in throat
- ☐ Lip sores/Canker sores

SKIN AND HAIR

- ☐ Dry skin
- ☐ Dry hair
- ☐ Loss of hair
- ☐ Oily skin
- ☐ Oily hair
- ☐ Acne/pimples
- ☐ Skin rash
- ☐ Itching
- ☐ Eczema
- ☐ Cysts/tumors
- ☐ Premature gray hair
- ☐ Dry brittle nails

TEMPERATURE

- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Cold hands and feet
- ☐ Hot hands and feet
- ☐ Alternating chills &fever
- ☐ Hot flashes

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Loose stools
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Blood or mucus in stool
- ☐ Painful bowel movements
- ☐ Frequent desire to eat
- ☐ Abdominal pain or cramps
- ☐ Addominal bloating
- ☐ Gallstones
- ☐ Abdominal pain
- ☐ Excessive appetite
- ☐ Tired after eating
- ☐ Heartburn/Acid reflux
- ☐ Belching/Hiccups
- ☐ Indigestion
- ☐ Foul odor

FEMALE CLIENTS ONLY

- ☐ Heavy menses - ____ days
- ☐ Light menses - ____ days
- ☐ Irregular menses
- ☐ Painful menses
- ☐ Blood clots
- ☐ Ovarian cyst
- ☐ Endometriosis
- ☐ Infertility
- ☐ Menopause
- ☐ Hysterectomy at age_____
- ☐ Pregnancies ____________
- ☐ Miscarriages ____________
- ☐ Abortions ______________

MALE CLIENTS ONLY

- ☐ Burning urination
- ☐ Impotence
- ☐ Prostatitis
- ☐ Premature ejaculation
- ☐ Painful/swollen testicles
- ☐ Sexual Difficulties
- ☐ Penile Discharge

Please circle which flavor you like most: Sweet Salty Bitter Spicy Sour

Please circle which flavor you like least: Sweet Salty Bitter Spicy Sour

LIFESTYLE HISTORY

Smoke cigaretts______________

Drink alcohol ______________

Drink coffee ______________

Drink tea ______________

Drink colas ______________

Use laxatives ______________

Take asprin ______________

Psychotherapy ______________

Exercise ______________

Meditate ______________

FAMILY HISTORY

- ☐ Alcoholism
- ☐ Asthma/Hay Fever
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Heart Diseas
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Scizophrenia
- ☐ Mental Illness

Significant Physical Trauma (Auto accident, Work-related accident, physical abuse, ect).

Date Describe

_______ ____

_______ ____

_______ ____

Significant Emotional Trauma (Divorce, Death Family/Friend, Abuse, Change of Home/Job)

Date Describe

_______ ____

_______ ____

_______ ____

Surgeries and/or Previous Serious Illnesses:

Date Describe

_______ ____

_______ ____

_______ ____

I understand that the Acupuncture and other therapies given here is for the purpose of balancing energy, increasing energy flow, stress reduction, relief from muscular tension or spasm, and other physical or emotional ailments. I understand that the Therapists do not diagnose illness, disease, or any physical or mental disorders. As such, the Therapists do not prescribe medical treatment, or pharmaceuticals, nor do they perform any spinal manipulations. I have stated all my known medical conditions and take it upon myself to keep the Therapist updated on my physical health.

Signature:____ Date____________