My Health Information

Name____Date________________________

Phone______________________ home?work?cell? Secondary Phone_______________________ home?work?cell?

Email____Birthday____________________

Address____

City/State/Zip____

How did you hear about us? ____

Emergency Contact___________________________relationship_______________phone____________________

Primary Health Care Provider____________________________________phone____________________

How would you like to feel?

____

____

What brought you here? Do you have specific health goals or concerns you would like to address?

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Have you previously experienced Shiatsu or other therapeutic bodywork? Y N

Please describe____

Typical areas of tension in your body____

Occupation____

Hobbies/Activities____

Are you sensitive to fragrances/sounds/light? Y N Please describe_________________________________

____

Do you have reason to believe you may be pregnant? Y N Which stage?_____________________________

Medical Information

It is important to know if you are under the care of a medical practitioner, what treatments or therapies you are currently undergoing, and if you are experiencing or have previously experienced any of the following conditions. *Please check all that apply and be sure to add detail (i.e. description of condition, year of incident), if applicable, in the 'Comments' section:*

____acute or chronic pain
____allergies
____anxiety
____autoimmune conditions
____bleeding disorder
____blood clots
____broken bones
____cancer/tumors (chemo?/radiation?)
____cortisone (or other) injections
____deep vein thrombosis (DVT)
____depression
____diabetes (injection?/pill?)
____digestive difficulties
____dislocated joints
____epilepsy/seizures (triggers?)
____fatigue/low energy
____fibromyalgia
____headaches
____heart condition/heart attack
____hernias
____high or low blood pressure
____HIV/AIDS
____infections/rashes
____inflammation or redness around joints
____joint replacement/s
____keloids (prone to?)
____lupus
____lymphedema
____kidney disease
____menstrual/menopause
____neuropathy
____osteoporosis
____pacemaker
____port (surgical implant)
____red or irritated skin or open wounds
____respiratory conditions
____serious injuries
____sleep difficulties
____stroke
____surgeries (please detail in the 'Comments' section)
____TMJD
____varicose veins
____other (please describe below)

Are you currently under a health provider's care for any of these (or other) conditions? Y N

Comments____

____

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Do you give permission to Ninetta Keenan to consult with your health care provider when appropriate, and only as it relates to the therapies administered to you at The Peaceful Healing Place/Inner Essence Shiatsu?

Y ___________(pls initial) N___________(pls intial)

Please list any medications (including aspirin/ibuprofen, etc.), herbs, vitamins, and supplements that you are taking____

____

____

Are you taking any medications that alter your ability to feel heat or pain? Y N

Please describe____

Are you currently experiencing a cold, flu or other infection? Y N

Please describe____

The information I have provided is accurate and complete to the best of my knowledge. I take responsibility for updating Ninetta Keenan of any changes in my health status, medications and therapies before each session.

It is my choice to receive Shiatsu and/or any adjunct therapy (i.e. Gua sha, Cupping, Moxibustion) and I generally release and discharge Ninetta Keenan from any responsibility or liability from these procedures.

I understand that the treatment being given is for the well-being of my body, mind and spirit. I agree to communicate with Ninetta Keenan any time I feel that my health and welfare are being compromised.

I have not been promised anything to submit to these procedures, or to sign this release form. No guarantees or warranties have been made to me as to the success, value, or benefit of such procedures.

____ _______________________________

Client Signature **Date**

(or signature of parent or guardian if under age 18)

Authorization for release of medical information:

I understand that my practitioner, Ninetta Keenan, may need to contact my health care provider/s when it is identified that my condition needs to be co-managed with my attending medical personnel. This coordination of care intends to manage my health condition for my highest good and assures the optimal outcome of the treatments provided by The Peaceful Healing Place/Inner Essence Shiatsu.

I give consent to The Peaceful Healing Place/Inner Essence Shiatsu for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations. I understand that I have the right to request restrictions on the use and disclosure of PHI, but The Peaceful Healing Place/Inner Essence Shiatsu is not required to agree to these restrictions and may refuse care. If The Peaceful Healing Place/Inner Essence Shiatsu agrees with my restrictions, the restrictions are considered binding. You may contact me for appointment reminders, schedule changes or other needs.

____ _______________________________

Client Signature **Date**

(or signature of parent or guardian if under age 18)

Private Session Letter of Agreement

The following conditions and understandings shall apply to all private sessions given at The Peaceful Healing Place/Inner Essence Shiatsu:

1) Zen Shiatsu and the adjunct therapies of Gua sha, Cupping and Moxibustion are not medical or psychotherapeutic procedures, and in no way diagnoses, nor pretends to effect a cure for any medically diagnosed condition. We represent our education and qualifications clearly and honestly, and make appropriate referrals to other health professionals where indicated.
2) Techniques applied may be varied according to your needs, and upon your practitioner's consideration. Your comfort zone for touch, degree of pressure and such requests shall be honored by the practitioner as much as possible within personal, professional and ethical limits.
3) Clear and honest communications will be maintained at all times between the parties. You agree to communicate any and all responses perceived to be a result of Shiatsu, Gua sha, Cupping and/or Moxibustion as soon as you become aware of them.
4) You understand and agree that no sexual activity, comment or innuendo will be tolerated.
5) You understand and agree that The Peaceful Healing Place/Inner Essence Shiatsu reserves the right to refuse services at its discretion based upon the client's condition, therapist's skill set, client attitude or action, etc., without explanation or prior notice.
6) All records and information, whether medical or personal, will be kept strictly confidential.
7) Discussion of your case will be done on an anonymous basis, and only with your express permission. Any discussions with your physicians or other therapists, in which case your identity is disclosed, will only be made with your full permission and full disclosure of the scope and content of that discussion.
8) You have the right to discontinue sessions at any time for any reason.
9) The Peaceful Healing Place/Inner Essence Shiatsu is dedicated to the healing arts and the wellbeing of the planet. As such we endeavor to provide care within the scope and limits of our discipline at all times. We honor the integrity of each and every person, and offer the highest quality care and attention that is within our power to provide.
10) Fees shall be agreed upon in advance and paid at the time of the session. Any cancellation must be made at least by 5pm the day prior to your scheduled appointment. If cancellation is made with less notice, a $25 fee will be assessed. Thank you for your professional consideration and courtesy.
11) This agreement shall be honored in perpetuity.

____   ________________________

Client's Signature   Date

(or signature of parent or guardian if under age 18)

____   ________________________

Practitioner's Signature   Date