

Jodi Baglien  
Shiatsu Therapist - Clinical Aromatherapist  
33 4<sup>th</sup> St. NW, Osseo MN 55369  
P: 612.802.9483 E: [jodi@baglien.com](mailto:jodi@baglien.com) www.jodibaglien.com

Natural Health Practitioners look to the roots of imbalance and which energetic system is showing the most symptoms. Therefore, your careful and thoughtful answers will provide you with a more effective session. **Even if you are just looking for a pleasant bodywork session and not concerned with any particular issues, please take the time to complete all relevant information.** Please ask if you have any questions.

Who should I thank for referring you? \_\_\_\_\_  
Or, how did you learn about my services? \_\_\_\_\_

Check here if you wish to be added to my mailing list. Used only by me for specials, events, classes.

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State / ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Date of birth \_\_\_\_\_  
Sex F M  
Name of current Medical Professional  
\_\_\_\_\_

What type of work do you do? \_\_\_\_\_  
How many hours per week? \_\_\_\_\_  
Do you enjoy your work? \_\_\_\_\_  
Have you ever had a Shiatsu session before? Yes No  
Emergency Contact Info.  
Name \_\_\_\_\_  
Phone \_\_\_\_\_

### Current Condition

Main problem(s) you would like help with today \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long ago did the problem(s) begin? - be specific \_\_\_\_\_

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

Have you ever been given a diagnosis for this problem(s)? If so, what diagnosis and by whom?  
\_\_\_\_\_  
\_\_\_\_\_

What kind of treatments have you tried, what has helped?  
\_\_\_\_\_  
\_\_\_\_\_

What medications, (drugs, herbs, oils, over the counter medications, vitamins) are you currently taking? \_\_\_\_\_

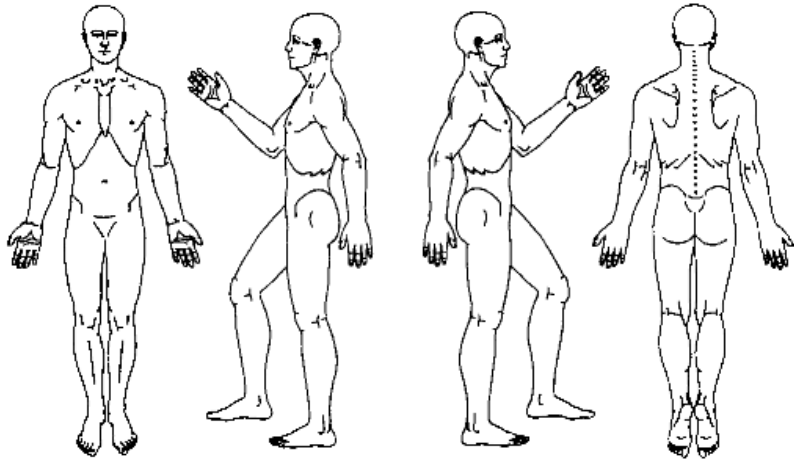
**Family History**

Please check any occurrence of the following in your family's history.

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Mental Illness    | <input type="checkbox"/> Kidney condition    |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> Liver condition   |  |

Please **circle** the areas on the body you are seeking help with

\*\*Please **place an X** on any recently injured areas, ticklish areas, varicose veins, or areas of the body you do not wish for me to touch.



**Please tell me more about the type of pain you experience**

Please check all that apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pain always in same area(s) | <input type="checkbox"/> Stiffness, cramping    | <input type="checkbox"/> Feels better with pressure  |
| <input type="checkbox"/> Pain moves around           | <input type="checkbox"/> Hot or Swollen         | <input type="checkbox"/> Rest helps                  |
| <input type="checkbox"/> Pain related to an injury   | <input type="checkbox"/> Area feels cool        | <input type="checkbox"/> Movement helps              |
| <input type="checkbox"/> Pain mostly in joints       | <input type="checkbox"/> Sharp and stabbing     | <input type="checkbox"/> Worse in cold weather       |
| <input type="checkbox"/> Pain mostly in muscle       | <input type="checkbox"/> Dull - aching          | <input type="checkbox"/> Worse in damp weather       |
| <input type="checkbox"/> Pain limits movement        | <input type="checkbox"/> Feels better with cold | <input type="checkbox"/> Numbness or heavy sensation |
|  | <input type="checkbox"/> Feels better with heat |  |

**Please list any significant physical trauma** (auto accidents, injuries, surgeries, work related injury, stress, physical abuse), etc

Date \_\_\_\_\_ Describe \_\_\_\_\_

Date \_\_\_\_\_ Describe \_\_\_\_\_

**Significant Emotional trauma** (divorce, deaths, difficult changes)

Date \_\_\_\_\_ Describe \_\_\_\_\_

Date \_\_\_\_\_ Describe \_\_\_\_\_

**Personal Health History**

Please check all that apply

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other STD's        |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Frequent Colds/Flu |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Bronchitis         |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> AIDS/HIV        | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Allergies –please describe | <input type="checkbox"/> Herpes          |   |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Chlamydia       |   |

## For Women Only

Are you:     pregnant    currently nursing                       planning to become pregnant  
Color of flow    Dark red     Bright Red     Heavy or  light bleeding  
Are there Clots?    Yes    No  
Last Period date: \_\_\_\_\_ Number of days of flow \_\_\_\_\_

Check symptoms you experience related to Menses

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Cramping               | <input type="checkbox"/> Hot flashes              | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Burning feeling        | <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Insomnia     |
| <input type="checkbox"/> Dull aches             | <input type="checkbox"/> Headache                 | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Stabbing pain          | <input type="checkbox"/> Swollen breasts          | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Bloating               | <input type="checkbox"/> Poor appetite            |                                       |
| <input type="checkbox"/> Bearing down sensation | <input type="checkbox"/> Increase/decrease libido |                                       |

## Diet

Please describe your diet

Balanced diet of natural foods & processed foods including; fruits, veggies, meat, dairy, grains.

Vegetarian    (If yes for how many years) \_\_\_\_\_

Vegan    (If yes for how many years) \_\_\_\_\_

My diet is...

- Heaviest on Meat (meaning red meat more than 3 days a week)  
 Heaviest on Pastas, breads, cereals    (circle) whole grain or processed  
 Heaviest on Sweets  
 Heaviest on Salty Snacks

- Coffee \_\_\_\_\_ cups per day  
 Soda \_\_\_\_\_ per day    diet    sugared  
 Microwaved food \_\_\_\_\_ times per week  
 Do you smoke? \_\_\_\_\_ # of Cigarettes per day  
 Alcohol    Light    Moderate    Heavy

## How is your sleep?

- Do you usually get to sleep within 20 minutes of retiring?                       Yes    No  
Do you often (3x week or more) wake up in the middle of the night?                       Yes    No  
If so, is urinary urgency the main factor in waking up?                       Yes    No  
Do you get back to sleep easily?                       Yes    No  
Do you feel refreshed after a typical night of sleep?                       Yes    No

If you awaken in the night, what time is it usually? \_\_\_\_\_ am/pm

How many hours of sleep do you typically get? \_\_\_\_\_ hrs.

Do you experience any pain at night that wakes you up? \_\_\_\_\_

Do you experience an energy drop at a regular time of day? \_\_\_\_\_

Any additional comments? \_\_\_\_\_

You're almost done – don't stop now!!!!

**Please mark as follows: Sometimes experience = X  
Frequently experience (daily- weekly) = XX**

**ST/SP**

- Appetite – too high, too low
- Tiredness
- Loose stools
- Constipation
- Chronic Sinus infections
- Indigestion/heartburn/reflux
- Bloating/gas after eating
- Belching, Vomiting, nausea, pain
- Mental fatigue - foggy
- Weak limbs – lack flexibility
- Undigested food in stool
- A feeling of retention of food in the stomach
- Bleeding gums
- Bruise easily
- Cold Limbs
- Tendency to become obsessive
- Worry too much

**HT/SI**

- Insomnia, difficulty sleeping
- Heart palpitations
- Anxiety
- Dizziness
- Insomnia
- Dream disturbed sleep
- Easily startled
- Blood clots
- Mental confusion
- Cold limbs
- Feeling of heaviness in chest
- Pain radiating down left arm
- Uncontrollable laughter or crying
- Spontaneous sweating

**TH/PC**

- Swollen lymphatic glands
- Nervous in social situation
- Tonsillitis
- Allergies
- High Blood pressure
- Low Blood pressure
  
- Sensitive skin
- Rashes
- Hives

**LU/LI**

- Chronic cough
- Shortness of breath
- Asthma
- Weak voice
- Dry throat, hoarseness, dry cough
- Daytime sweating
- Nighttime sweating
- Skin problems, eczema, and psoriasis
- Toothaches

**LV/GB**

- Pain – general body pain
- Sighing (do you notice yourself sighing)?
- Depression
- Numbness in extremities
- Tics or tremors
- Dizziness
- Anemia
- Eyes – blurred, floaters, dry, red?
- Dry skin/hair – brittle nails
- Stiff neck/ joints - chronic
- PMS – any related issues
- Headaches  Diarrhea
- Flashes of anger
- Bitter taste in mouth

**KI/UB (Qi, yin, yang jing def.)**

- Asthma
- Cold limbs
- Excess urination
- History of Urinary tract infections
- Incontinence
- Dizziness
- Tinnitus – ringing in ear
- Night sweats
- Sore or weak back
- Knee – sore or weak
- Edema
- Aversion to cold
- Weak bones, teeth
- Low Libido/ Sexual dysfunction

This information is confidential and will only be used to develop a best possible treatment for your specific pattern/needs. If following your treatments, you think of other symptoms that may be relevant to your health patterns, please let me know. Thank you.

Client signature \_\_\_\_\_