Jodi Baglien
Shiatsu Therapist | Clinical Aromatherapist

CLIENT INTAKE FORM
Jodi Baglien, LLC

Hello! Thank you for choosing me to help you regain balance, energy, and living life to the fullest. Please take your time with this intake – no matter how we work together, the information you provide assists me to decide where and how we work together to meet your needs so you can feel better, live happier. Please take your time – I suggest you stay focused on what is happening for you right now – but give all relevant health concerns as asked. ***Even if you are just looking for a pleasant bodywork or aromatherapy session and not concerned with any particular health issues, please take the time to complete all information.***

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. Enter email CLEARLY** _____

Today's Date _____
Name _____
Address _____
City _____
State / ZIP _____
Phone _____
Email _____
Date of birth _____
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

Briefly tell me, what would you like help with today?
_____ _____
_____

On a scale of 1 -3, or low- medium – high, 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 has been prescribed, or suggested? What has helped?
_____
_____

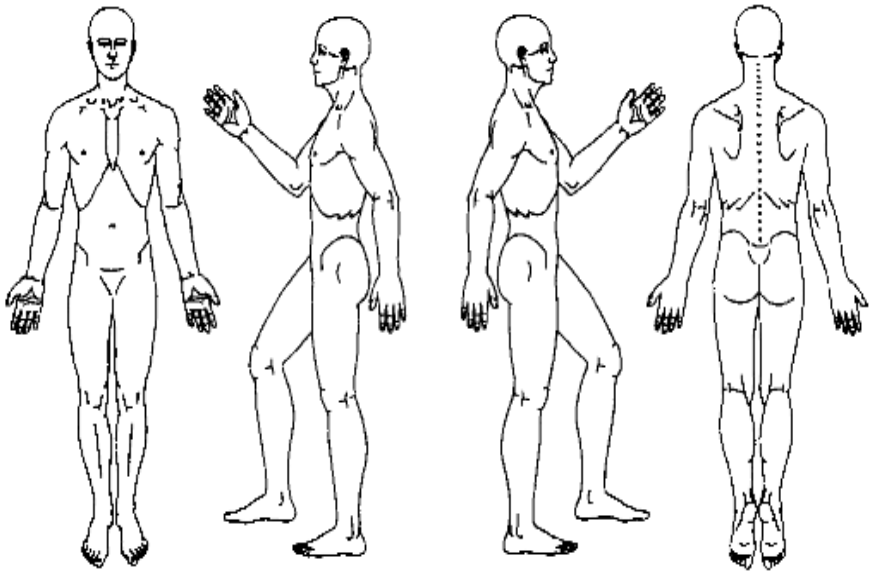
What medications, (drugs, herbs, oils, over the counter medications, vitamins) are you currently taking?
_____

Self care is important - are there any daily practices you currently and consistently do that help you feel better? If so please list them.

_____

_____

As closely as possible – please draw on the bodies exactly where you are experiencing the pain, stress, issues. If more than one issue, use another color.



Place an X over any areas that are recently injured recent surgery, deep bruising, varicose veins, or ticklish.

Please tell me more about the type of pain you experience

Please check all that apply

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

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

☐ Cancer
☐ Diabetes
☐ Hepatitis
☐ High Blood Pressure
☐ Asthma
☐ Allergies –please describe
☐ Heart Disease
☐ Thyroid Disease
☐ Seizures
☐ Pneumonia
☐ AIDS/HIV
☐ Herpes
☐ Chlamydia
☐ Other STD's
☐ Frequent Colds/Flu
☐ Bronchitis
☐ Other _____

For Women Only

☐ Rheumatic Fever ☐ Drug/Alcohol Abuse

Are you: ☐ pregnant? ☐ Currently nursing? ☐ Planning to become pregnant?

☐ In peri menopause? ☐ In menopause?

Check symptoms you experience related to Menses

☐ Cramping
☐ Burning feeling
☐ Dull aches
☐ Stabbing pain
☐ Bloating
☐ Bearing down sensation
☐ Hot flashes
☐ Mood swings
☐ Headache
☐ Swollen breasts
☐ Poor appetite
☐ Increase/decrease libido
☐ Night sweats
☐ Insomnia
☐ Diarrhea
☐ Other _____

Diet

Please describe your diet What foods do you eat the most of? And, is there anything you CRAVE?

_____
_____

☐ Coffee? Cups per day_____
☐ Soda _____ per day ☐ diet ☐ sugared
☐ Micro waved food _____ times per week
☐ Do you smoke? _____ # of Cigarettes per day
☐ Alcohol ☐ Light ☐ Moderate ☐ Heavy

Good nutrition and food that fits your body type is so important to your health, is there anything else about food you want to mention or want help with?

_____
_____

How is your sleep?

Do you usually get to sleep within 20 minutes of retiring? ☐ Yes ☐ No
Do you often wake up in the middle of the night? (3x week or more) ☐ 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
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? _____

If sleep is an issue for you –rate your stress level here :- ___low ___med _____high

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

ST/SP

__ Tired, for no apparent reason
__ Digestive issues __ stomach __ bowel
__ Loose stools or constipation
__ Chronic sinus issues, infection, nasal drip
__ Weakness in muscles, limbs
__ Mental fatigue – foggy/heavy head
__ Hold extra weight easily
__ Crave sweets
__ Bleeding gums
__ Bruise easily
__ Cold Limbs
__ Over think/over worry
__ Indecisive
__ Overly involved in taking care of others
__ Sensitive to criticism
__ Often disappointed

LV/GB

__ Pain in joint/connective tissue
__ PMS –
__ Hemorrhoids __varicose veins
__ Anemia
__ Headaches
__ Neck and shoulder tension
__ Tics or tremors
__ Bitter or metal taste in mouth
__ Sighing (do you notice yourself sighing)?
__ Eyes __ blurred __ floaters __ dry__ red?
__ Dry skin/hair __ brittle nails
__ Depression – prone to?
__ Anger, frustration, irritable
__ When stressed - blow or burst in anger
__ Lack motivation

HT/SI

__ Insomnia, difficulty sleeping
__ Heart palpations / heart issues history
__ Dizziness
__ Cold limbs – poor circulation
__ High or low blood pressure
__ Dream disturbed sleep
__ Feel heat in the face, head, flushed
__ Pale face
__ Anxious, agitation, restless, jumpy
__ Overly emotional /sensitive
__ Poor memory, forgetful, scattered
__ Compulsive behaviors
__ Disconnected, socially uncomfortable
__ Uncontrollable, inappropriate laughter or crying

KI/UB

__ Low back issues - weak, pain, chronic
__ Knees – sore or weak, chronic issues
__ Cold limbs
__ Urinary problems –current or history of
__ Tinnitus – ringing in ear
__ Dark circles under eyes
__ Night sweats
__ Edema
__ 5 pm fatigue
__ Aversion or sensitive to cold
__ Weak bones, teeth
__ Low Libido/ Sexual dysfunction
__ Overly fearful, dislikes change
__ Strong fear of failure
__ Feel insecure, tend to withdraw, or timid
__ No fear - reckless behaviors

LU/LI

__ Prone to respiratory issues
__ Asthma
__ Experience shortness of breath easily
__ Sensitive skin, dry, eczema/psoriasis
__ Rashes _____ Hives
__ Halitosis – bad breath
__ Perfectionist type
__ Deep feelings of sorrow, sadness, grief
__ Withdrawn, distant
__ Feel powerless
__ Rigid thinker

Aromatherapy -

__ Any known allergies to plants?
__ Do you consider your skin highly sensitive
__ Are you receiving treatment for cancer?

__ Do you have a favorite oil/aroma?
_____

Do you have a oil/aroma you don't want used? _____