Client History

Gracie Hvidston, CST.
Certified Shiatsu Therapist, Reiki Master

Date:.....

Last Name: ..... First Name:.....

Date of Birth: ..... Occupation: .....

Address: ..... Postal Code:.....

Telephone: Home..... Cell

.....

email: ..... Referred by: .....

Family Physician:..... Phone Number: .....

Emergency Contact (name and number): .....

Please circle if you have ever suffered from the following:

Heart problems	Headaches	High Blood Pressure	Nerve problems	Asthma
Migraines	Insomnia	Low Blood Pressure	Constipation	Arthritis
Rheumatism	Depression	Digestive Complaints	Chronic Fatigue	Diabetes
Hormone Imbalance	Diarrhea	Circulatory problems	Respiratory Issues	Fibromyalgia

Please list all allergies:

.....

Are you currently taking medication: (Please list all herbs and pharmaceuticals)

.....

....

Have you had any major head trauma, injuries or surgeries? .....

.....

....

Any major illnesses (cancer, HIV, etc) ?.....

For Women: You are - menstruating - premenopausal - menopausal (please circle one)

Do you experience any of the following:

cramping clotting sharp painachy pain low back pain bloating
depression cravings headaches mood swings abdominal pain