

ACUPRESSURE 2 LOG SUMMARY FORM

Name: _____

WEEK	DATE DUE	WEEKLY GIVING	WEEKLY RECEIVING	TOTAL GIVING	TOTAL RECEIVING
3		2	0		
5		2	1		
9		3	0		
11		3	1		
TOTALS		10	2		

Acupressure Questionnaire

Name _____ Date of Birth _____

Address _____ Time of Birth _____

City _____ State _____ Zip _____

Phone (day) _____ (eve) _____ eMail _____

Occupation _____ Referred By _____

Posture assumed most during day

Areas of Tension (check all that apply):

- | | | |
|-------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Head/Face | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Buttocks |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Low Back | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Arms/Hands | | |

Medical History - Please indicate below any significant medical conditions:

- Skin condition (e.g. rash, dermatitis, eczema, acne)
- Circulatory condition (e.g. heart disease, varicose veins, arteriosclerosis, high/low blood pressure)
- Lymphatic condition (e.g. swollen glands, lymphedema)
- Neurological condition (e.g. sciatica, numbness/tingling in any area of body, stroke, epilepsy)
- Endocrine system (e.g. hormone imbalances, diabetes, thyroid conditions)
- Joint problems (e.g. hypermobility, arthritis, sacroiliac problems, bulging discs)
- Bone conditions (e.g. osteoporosis, cancer, bone spurs)
- Headaches (e.g. migraines, tension, PMS) Location of Headaches _____
- Emotional difficulties (e.g. depression, anxiety, mood swings)
- Accidents (please describe):
- Injuries (please describe):
- Surgeries (please describe):

(Over Please) →

Please indicate any conditions involving the following organs:

- | | |
|---------------------------------|--|
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Small Intestine |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Large Intestine |
| <input type="checkbox"/> Spleen | <input type="checkbox"/> Bladder |

For each category - Circle the choices you **Prefer/Express**; **X** the choices you **Dislike/Don't Express**:

Color	Green	Red	Yellow	White	Blue/Black
Climate	Wind	Heat	Damp	Dry	Cold
Season	Spring	Summer	Late Summer	Fall	Winter
Emotions	Anger	Joy	Worry	Grief	Fear
Tastes	Sour	Bitter	Sweet	Spicy	Salty

For each row – Check (✓) one statement that most accurately describes you:

Tired	Restless	Restless with underlying tiredness
Sleep heavily	Can't get to sleep / restless sleep	Get to sleep but wake frequently
Cold body	Hot body	Hot hands and feet
Cold day and night	Hot day and night	Hot mainly during afternoon/night
No thirst	Strong thirst	Thirst mainly during afternoon/night
Pale face	Red face	Red cheeks (flushed)
Copious, clear urine	Scanty, dark urine	
Loose stools	Constipated with possible pain	Dry stools with no pain
Listless	Agitated	Anxious
Unconfident	Strong willed	Defensive
Apathetic	Driven	Over-extended

Habits:

Exercise (please describe type & frequency):

Tobacco Alcohol Caffeine

Do you consider your diet to be healthy? (Yes / No / Somewhat)

Medications - Please list any currently being taken:

Primary reason(s) for receiving massage/acupressure:

Name of primary health care provider:

_____ Phone: _____

Do I have permission to contact him/her if the need arises? (Yes / No)

Signature _____ **Date** _____

The information disclosed will remain confidential. Thank you for your time and trust.

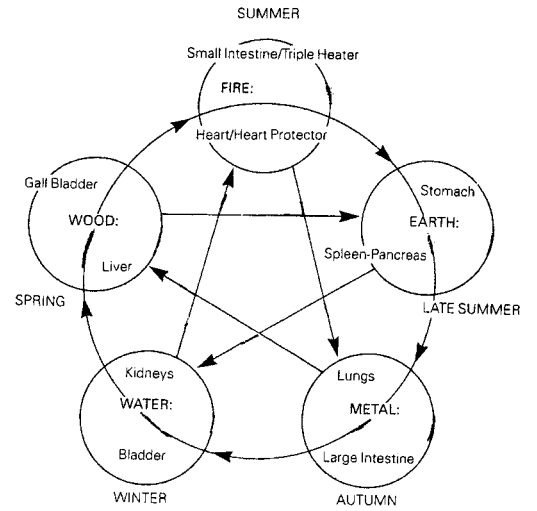
ACUPRESSURE SOAP NOTES

Giving ___ Receiving ___ Date _____
 Giver Name _____
 Receiver Name _____
 Duration of Session _____
 Actual acupressure time _____

Kyo _____ Jitsu _____

YIN	YANG
Interior	Exterior
Cold	Hot
Empty	Full

Lu	3-5am
LI	5-7am
St	7-9am
Sp	9-11am
Ht	11am-1pm
SI	1-3pm
Bl	3-5pm
Ki	5-7pm
PC	7-9pm
TB	9-11pm
GB	11pm-1am
Li	1-3am



SUBJECTIVE: (Client report, observations, reasons for coming)

OBJECTIVE: (Palpatory and other observations, identified session goals - **Why chosen?**)

ASSESSMENT: (Changes in client condition, evaluation of techniques – **Diagnosis supported?**)

PLAN: (Future plans for working with client, client homework, recommendations)
