

Name _____ Mailbox _____

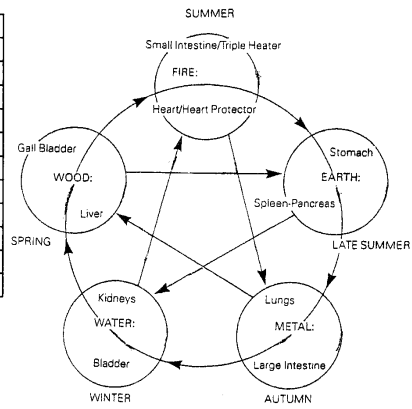
ACUPRESSURE LOG SUMMARY FORM

WEEK	DATE DUE	TOTAL DUE	WEEKLY GIVING	WEEKLY RECEIVING	TOTAL GIVING	TOTAL RECEIVING
		G R				
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13					16	4

ACUPRESSURE SOAP NOTES

Date _____
 Giver _____
 Receiver _____
 Occupation _____
 Age _____
 Session Length _____
 Actual Acupressure time _____

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: (Identified session goals – meridians and points to be used)

ASSESSMENT: (Palpation/clinical findings, changes in client condition, meridians/points chosen)

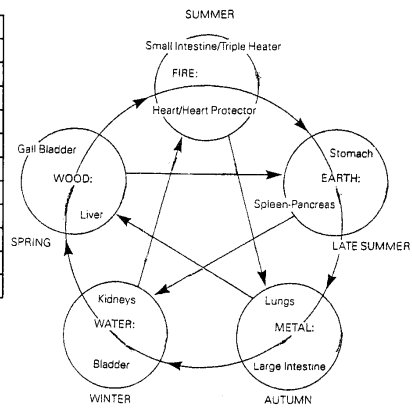
PLAN: (Future plans for working with client, recommendations)

SELF-CARE: (Body mechanics, issues regarding positioning)

ACUPRESSURE RECEIVING LOG

Date _____
 Receiver _____
 Giver _____
 Occupation _____
 Age _____
 Session Length _____
 Actual Acupressure time _____

Lu	3-5am
LI	5-7am
St	7-9am
Sp	9-11am
Ht	11am-1pm
SI	1-3pm
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SUBJECTIVE: (Goal for this session? What symptoms are you reporting?)

OBJECTIVE: (Palpatory observations and mind/body awareness that came up as you received)

ASSESSMENT: (Technical aspects of the massage. Body areas and meridians addressed.)

PLAN: (Review effectiveness of session and what you and therapist will do next session)

COMMENTS: (Notes for yourself, areas of clarification)

Acupressure Intake Form

Name _____ Date of Birth _____

Address _____ Time of Birth _____

City _____ State _____ Zip _____

Phone (day) _____ (eve) _____ eMail _____

Occupation & 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 - Indicate below any significant medical conditions (check all that apply):

- Skin condition (e.g. rash, dermatitis, eczema)
- 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)
- Immune system (e.g. Chronic Fatigue Syndrome, Epstein-Barr, HIV)
- Joint problems (e.g. hypermobility, arthritis, sacroiliac problems)
- Bone conditions (e.g. osteoporosis)
- Headaches (e.g. migraines, tension, PMS)
- Accidents/Injuries (describe type and date):
- Surgeries (describe type and date):
- Other _____

(Over Please) →

Exercise (describe type & frequency): _____

Emotions

Are you able to express your emotions/feelings? _____

Are you too emotional or not emotional enough? (Circle one if it applies)

Which emotions do you feel predominantly? Check all that apply below:

Anger ___ Sadness ___ Fear ___ Sympathy/Worry ___ Joy ___ Depression ___

Other _____

What is your stress level in life? Rate from 1 to 10 (1=low, 5=medium, 10=high) _____

What causes your stress? (family, work, finances, relationships?) _____

Do you have a favorite time of day? (Yes / No) If yes, what time? _____ am/pm

Is there a low point in your day? (Yes / No) If yes, what time? _____ am/pm

What is your favorite climate/weather? _____

What climate/weather do you dislike? _____ Why? _____

What is your favorite season? _____

What is your favorite color? _____

Are you happy with your general energy level? (Yes / No) If no, why not? _____

What is your intention for receiving acupressure?

In what way(s) could your therapist best support you?

All Clients

Primary health care provider _____ Phone: _____

Do I have permission to contact provider and/or therapist if the need arises? (Yes / No)

Signature _____ Date _____

The information disclosed will remain confidential. Thank you.