Atsumi

DETOX.YOGA.HEALING

REGISTRATION FORM

Name:			Date:		
Address:					
DOB:		Gender:		Age:	
Height:	cm	Weight:	kg	PH Level:	
Bloodpressure:	mmHg	Pulse:	bpm	Other:	
EMAIL:		Person to contact in case of any emergency:			

Reasons for your visit	Comments
What would you most like to achieve by coming to Atsumi? What level of help would you like to receive to assist you in reaching your goals?	
GeneralState of health	**Comment**
General health and well-being? Do you have any active health concerns, illness or present discomfort?	
Gastro-Intestinal	**Comment**
How would you describe your digestion? ☐ Heartburn ☐ Gas ☐ Pains ☐ Bloating ☐ Constipation ☐ Indigestion ☐ Stool-undigested food,colour,smell, float/sink	

Diet	Comment
Do you follow a specific diet or food preference? Do you have any specific foods ensitivities, intolerance or allergies? Do you have any food cravings? How much do you drink per day or week? Water:…… Dairy/Soy:……. Alcohol:…… Juices:…… Tea:…… Coffee:…… Soft Drinks:…… Cordials/Concentrates:…… Protein drinks:……Electrolyte drinks:……	
Circulatory	**Comment**
Do you have a history of high or low blood pressure? Do you have high cholesterol? Family history of heart disease? Do you have any problemwith: ☐ Hemorrhoids ☐ Varicose Veins ☐ Chestpains ☐ Palpitations	
Nervous System	**Comment**
☐ Headaches ☐ Migraines ☐ Fainting/loss of balance ☐ Poor Memory	
Endocrine	**Comment**
☐ Diabetes ☐ Hypoglycemic ☐ Thyroid problems	
Respiratory	**Comment**
☐ Asthma ☐ Shortness ofbreath ☐ Smoking ☐ Recreational drugs ☐ Sinus problems ☐ Allergies/hayfever ☐ Other Colds/flu etc per year?.....	

Reproductive/Urinary	Comment
Is there anything you wish to mention about your menstrual cycle or reproductive system? ☐ PMS ☐ Peri-menopause ☐ Incontinence ☐ Prostate ☐ Infections ☐ Others	
Musculoskeletal	**Comment**
☐ Joint pain/stiffness/swelling/arthritis/range of movement issues? Where? ☐ Bone Fractures ☐ Backpain/Sciatica Past treatments? Did they help/benefit?	
Skin	**Comment**
☐ Rashes/Eczema/Hives/Psoriasis Hair/Nail ☐ Changes(colour/shine/loss)	
Exercise/fitness	**Comment**
Normal forms of exercise? Frequency/duration? Any forms of exercise/fitness you have an interest in learning, developing further or having PT in?	Goals: ☐ Flexibility ☐ Cardiovascular ☐ Muscular balance ☐ Strength Development ☐ Weightmanagement
Stress	**Comment**
Do you find stress in your daily life? How do you react and manage your stress? Do you have any problems sleeping? Sleeping Aids? How many hours do you work and or travel per day? How are your energy levels?	
Medicationand Supplementation	**Comment**
Are you undergoing any medical treatment, taking any medication/supplement or consulting and other practitioner e.g.osteopath,acupuncturist or homeopath?	☐ YES ☐ NO
Others	**Comment**
☐ Pacemaker ☐ Contacts/glasses ☐ Implants ☐ Metal pins/plates ☐ Hearingaid ☐ IUD	

I hereby certify that the above is a true, accurate and correct account of my medical history. I understand that there are safety and health precautions with the facilities, treatment, programs and consultations at Atsumi Retreat Healing Center Co. Ltd. I accept full liability for my decision to utilize any and/or participate in Atsumi Retreat Healing Center Co. Ltd. Facilities, treatment programs, consultation and/or advice/recommendation/guidance, and I will not claim or demand for any responsibility from Atsumi Retreat Healing Center Co. Ltd. Their staff or management should I experience any adverse reaction, loss or damage to myself or my property with any treatment, facility, program/s, consultation/s and/or advice/recommendations/guidance associated with Atsumi Retreat Healing Center Co. Ltd.

Signature:…… Date: ……..

Atsumi Staff

signature:…… Date: ……..