CLIENT INFORMATION

NAME:_____ DATE:_____

ADDRESS_____

CITY:_____ STATE:_____ ZIP:_____

PHONE – HOME:_____ CELL:_____

May we leave a v-mail message on your home/cell numbers: YES NO

May we leave a message with a spouse, partner or other persons (state name/relationship): YES NO

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ MALE FEMALE

(CIRCLE ONE): SINGLE WIDOWED DIVORCED HAVE A SPOUSE OR PARTNER

NAME OF SPOUSE OR PARTNER:_____

NUMBER OF CHILDREN: _____

IF REFFERED, BY WHOM: (PATIENT / THERAPIST / DOCTOR – NAME AND PHONE NUMBER)

_____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____PHONE:_____

Have you ever had Craniosacral Therapy? YES NO massage therapy? YES NO

What are your treatment objectives or goals?

_____

_____

_____

_____

Date of injury or onset of illness: _____

If accident, list type (auto, worker's comp, personal injury, etc.) _____

What makes problem worse? _____

_____

What makes problem better? _____

_____

What other treatments have you received for this problem? _____

_____

Do you have any difficulty with any of the following areas?

___ Fever
___ Diabetes
___ High blood pressure
___ Cancer
___ Heart condition
___ Kidney condition
___ Skin disorder or sensitivity
___ Nerve condition
___ Slipped/crushed disc
___ Arthritits
___ Bladder trouble

___Asthma
___Low blood pressure
___Liver trouble
___Persistent abdominal pain
___Shortness of breath
___Sinus trouble
___Headaches
___Shooting head/neck pain
___Ringing in ears
___Tightness of shoulder muscles
___Muscle spasm in neck

___Creaking in neck
___Dizziness
___Tightness of throat
___Ulcers
___Sacral or low back pain
___ Pain on inner legs/heels
___Shallow breathing
___Swollen joints
___Pins/needles in arm/leg
___Inner tension
___Decrease in energy

Do you have allergies? YES NO Describe: _____

Have you ever -

Had surgery? YES NO Describe: _____

Broken any bones? YES NO Describe: _____

Had a severe illness? YES NO Describe: _____

Been in an accident? YES NO Describe: _____

HABITS:

ALCOHOL:	HEAVY	MODERATE	LIGHT	NONE
COFFEE:	HEAVY	MODERATE	LIGHT	NONE
TEA:	HEAVY	MODERATE	LIGHT	NONE
TOBACCO:	HEAVY	MODERATE	LIGHT	NONE
EXERCISE:	HEAVY	MODERATE	LIGHT	NONE
SUGAR:	HEAVY	MODERATE	LIGHT	NONE

*Payment is required **at the time of service** and you are responsible for all fees.

***Please provide 24 hours cancellation notice** if you are unable to keep your appointment.

*If we are not notified 24 hours in advance, **we will charge you for your missed appointment.**

MY SIGNATURE CONFIRMS THAT I AM AWARE OF AND AGREE TO THE ABOVE.

SIGNATURE: _____ DATE: _____

IF PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

NAME OF LEGAL PARENTS OR GUARDIAN: _____

PHONE NUMBER: _____