Craniosacral Therapy Patient Information

Date_______________ How did you hear about our practice__________________________________

Name ____ Birthdate________________________

Address____ Phone__________________________

City___________________________State_____ Zip__________Cell Phone ___________________________

Email ____

Current Relationship Status___________________________ How Long _____________________________

Please describe your feelings about your current relationship: ____

____

Children (names and ages) ____

____

Occupation ________________________________ Employer _____________________________________

Main Concerns for Visit: ____

____

____

____

List any physical trauma (broken bones, stitches, accidents, operations)that have take place

____

____

Please list any emotional trauma, stress or major life changes that you have experienced

____

____

Please briefly describe your lifestyle (eating habits, sleep, exercise, hobbies, how you relieve stress, spiritual preferences, anything that will help me know you better) ____

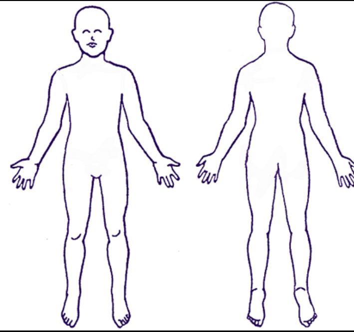
____

____

____

Please check any you have had in the past or currently experience:

❏ broken/fractured bones ❏ headaches/head injuries ❏ low back, hip, leg pain ❏ shoulder, arm pain ❏ jaw pain/TMJ	❏ neck pain ❏ arthritis ❏ migraines ❏ high fever	❏ asthma ❏ sinus problems ❏ bruise easily ❏ epilepsy/seizures	❏ depression ❏ heart condition ❏ constipation ❏ anxiety/stress

❑ allergies; specify_______________________________________ ❑ numbness/tingling, ❑ Are you sensitive to or have allergies to essential oils? ❑ Are you allergic to latex ❑ Do you have any other medical conditions I should know about_______________________________________ _______________________________________ **Please mark on figures to right any pain, tingling or spasms.**	

YOUR BIRTH HISTORY/CHILDHOOD
Please do your best to answer the following questions regarding your mothers pregnancy:

What type of delivery did you have? ❑ vaginal ❑ C-section ❑ forceps ❑ full term ❑ preemie (how early)___________

Check all that your mother experienced during pregnancy: o❑Cigarette smoking ❑ Lived with a smoker ❑ Drank Alcohol ❑ Recreational drugs ❑ Prescription Drugs ❑ Physical abuse ❑ Emotional abuse

Were you breastfed ❑Yes ? ❑ No Until what age _________________________

Did you feel safe growing up? ❑ Yes ❑ No Please briefly describe your childhood:
____
____

Describe your relationship with your parents and family from childhood to the present_____________
____
____
____

Women Only:
Have you ever been pregnant? ❑ Yes ❑ No If yes, how many times _________________________________
Please describe pregnancy: ____
Have you ever lost a child to miscarriage, abortion, stillbirth or death? ❑ Yes ❑ No If yes, please explain circumstances, ____
____

Consent for Care: I have completed this form to the best of my knowledge and will inform my therapist about any change in my health. I understand the bodywork and somatic therapy is being given for the well being of body, mind and spirit. This includes stress reduction, relief of emotional and physical connective tissue restrictions, spasm or pain. I realize that bodywork should not be construed as a substitute for medical examination, diagnosis or treatment, and that nothing said in the course of action shold be construed as such.

Payment Policy: Payment is due at time of service unless prior agreement has been made. Statements for insurance billing are available by request, however service cannot be rendered on the assumption that charges will be paid by insurance companies. Please kindly give 24 hrs notice to cancel or reschedule appointments to avoid being charged.

I have read to and agree to these above policies.

Client Signature ____Date_________________

Printed Name: ____