Sarah's

CRANIOSACRAL INTEGRATED THERAPIES

CLIENT INFORMATION

Please take care to fill out this form thoroughly and carefully. The information will help your CranioSacral therapist provide optimal care. Your cooperation is deeply appreciated.

Name ______________________ Date ____________

Address ______________________

City ______________ State ________ Zip ________

E-mail ______________________

Phone: *Please check the box of the number that you prefer I use to reach you*

❒ Home ____________ ❒ Cell ____________ ❒ Office ____________

Age: *(required for insurance billing)* ____________ Birth date ____________

Occupation ______________________

Referred by ______________________

Emergency contact person ______________________ Phone ____________

Number of children and their ages ______________________

____

Have you previously experienced CranioSacral Therapy? ❒ Yes ❒ No

Are you currently under a physician's care for any condition? ❒ Yes ❒ No

If ***yes***, please describe ______________________

Physician's name ______________ Phone ____________ Fax ____________

HEALTH HISTORY

Primary reason for today's visit

Areas of complaint, pain, tension

Your goal for this session

Are you aware of any emotional distress flowing from an injury?

Have you suffered from any form of abuse?

Any secondary complaints you would like to address?

How and when did your major symptoms begin? *(For example, did they begin as a result of an accident or injury or did they begin without any apparent reason?)*

Have you ever received any other treatments for this condition? If yes, please indicate the type of treatment, length of treatment and effectiveness.

What activities or body positions increase your pain and what activities or positions decrease the pain.

Place a mark on the line below to indicate the INTENSITY of the pain right now.

NONE ________________ WORST POSSIBLE

Put two marks on the line below to indicate the WORST and BEST your symptoms have been during the past week.

NONE ________________ WORST POSSIBLE

Place a mark on the line below to indicare the FREQUENCY of your symptoms.

SELDOM ________________ CONSTANT

Mark the lines below to indicate your daily functional ability as a percentage of normal.

On a “good day”: 0% ________________ 100%

On a “bad day”: 0% ________________ 100%

*Please circle **C** for Current, **P** for Past issues.*

EMOTIONAL

Depression C P
Eating Disorder C P
Mood Swings C P
Substance Abuse C P

AUTO-IMMUNE

AIDS / HIV C P
Allergies C P
Cancer C P
Fatigue C P
Fever *(severe)* C P
Fibromyalgia C P
Fungal Infections C P
Herpes C P
Lyme Disease C P
Mononucleosis C P

CARDIOVASCULAR

Angina C P
Stroke C P
Heart Attack C P
Hypertension C P

URINARY

Bladder Infection C P
Kidney Stones C P

ENDOCRINE

Adrenal C P
Pituitary C P
Hyperthyroid C P
Hypothyroid C P

NEUROLOGICAL

Epilepsy C P
Dizziness C P
Insomnia C P
Migraines C P

MUSCULAR-SKELETAL

Arthritis C P
Back Pain C P
Carpal Tunnel C P
Gout C P
Skin Disorder C P

EAR, NOSE, THROAT

Earache C P
Jaw Pain (TMJD) C P

RESPIRATORY

Bronchitis C P
Emphysema C P
Pneumonia C P
Tuberculosis C P

DIGESTION

Constipation C P
Diabetes C P
Diarrhea C P
Hepatitis C P
Hypoglycemia C P
Jaundice C P
Ulcer C P
Liver Disorder C P

REPRODUCTIVE

STD's C P
Endometriosis C P
Miscarriage(s) C P
Abortion(s) C P
Female Organs C P

ABUSE

Sexual Abuse C P
Physical Abuse C P

OTHER ISSUES

____

____

____

____

❒ Yes ❒ No Do you wear contact lenses?

❒ Yes ❒ No Do you wear dentures?

❒ Yes ❒ No Have you had extensive dental work *(bridges, braces etc)*?

❒ Yes ❒ No Car accident *(at any time)*, serious falls, other injuries?

❒ Yes ❒ No Do you have any allergies? If yes, describe: ______

❒ Yes ❒ No Do you have arthritis? Please describe what type and where: ______

❒ Yes ❒ No Do you have any heart problems? Please describe: ______

❒ Yes ❒ No Do you have any spinal problems? Please describe: ______

❒ Yes ❒ No Are you pregnant? How far along? ______ months. Complications? ______

❒ Yes ❒ No Have you had surgery? When ______ Complications? ______

❒ Yes ❒ No Do you take prescribed medicines? List: ______

❒ Yes ❒ No Do you an implanted medical device? Describe: ______

❒ Yes ❒ No Do you exercise regularly? Describe: ______

❒ Yes ❒ No Are you currently receiving other complementary care *(chiropractic, naturopathic, acupuncture, homeopathic, hypnotherapy, nutritional, herbal, other)*? Please describe:

❒ Yes ❒ No Do you have other physical or mental conditions I should be aware of before giving you a CranioSacral therapy session? If yes, please describe:

*Please circle **C** for Current, **P** for Past issues.*

MAJOR MEDICAL

Heart Disease	C	P
Cancer	C	P
Blood Pressure	C	P
Diabetes	C	P
Stroke / CVA	C	P
Epilepsy / Seizures	C	P
Lung Disease	C	P
Aneurysm	C	P

CIRCULATORY

Hypertension	C	P
Edema	C	P
Reynaud's Disease	C	P
Varicose Veins	C	P
Heart Attack	C	P
Cardiovascular Disease	C	P
Blood Clots	C	P
Bleeding Disorder	C	P
Diabetes *(Type 1 or 2)*	C	P

DIGESTIVE

Ulcers	C	P
Colitis	C	P
Gallstones	C	P
Hepatitis / Liver Disease	C	P
Constipation	C	P
Diarrhea	C	P
Gas / Bloating	C	P
Indigestion / Heartburn	C	P
IBS / Cohn's Disease	C	P

NERVOUS SYSTEM

Shingles	C	P
Multiple Sclerosis	C	P
Parkinson's Disease	C	P
Bell's Palsy	C	P
Spinal Cord Injury	C	P
Seizure Disorders	C	P
Numbness / Tingling	C	P

CIRCULATORY

Pneumonia	C	P
Sinus Problems	C	P
Allergies	C	P
Asthma	C	P

SKIN

Fungal Infections	C	P
Impetigo	C	P
Dermatitis / Eczema	C	P
Psoriaris	C	P
Cosmetic Surgery	C	P

UROGENITAL

Coccyx Pain	C	P
Intercourse Pain / Dysparuenia	C	P
Cystitis / Chronic UTI	C	P
Painful Urination	C	P
Frequent Urination	C	P
Kidney Disease	C	P
Endometriosis	C	P
Fibroids	C	P
Menstrual Issues	C	P

PAIN CONDITIONS

Arthritis *(Osteo/Rheum)*	C	P
Bursitis	C	P
Headache / Migraines	C	P
TM / Jaw Pain	C	P
Low Back Pain	C	P
Neck Pain	C	P
Knee Pain	C	P
Hip Pain / Pelvic Pain	C	P
Rotator Cuff Problems	C	P
Sciatica	C	P
Pinched Nerve	C	P
Thoracic Outlet Syndrome	C	P
Carpal Tunnel Syndrome	C	P
Plantar Fascitis	C	P
Fibromyalgia	C	P
Spasms / Cramps	C	P
Sprains / Strains	C	P
Tendonitis	C	P
Whiplash	C	P

MISCELLANEOUS

Osteoporosis	C	P
Hernia	C	P
Difficulty Sleeping	C	P
Tinnitus	C	P
Sleep Apnea	C	P
Dizziness / Vertigo	C	P
Anxiety / Panic Attacks	C	P
Depression	C	P
Thyroid Condition	C	P
HIV	C	P
Lupus	C	P

CONDITIONS NOT LISTED ABOVE

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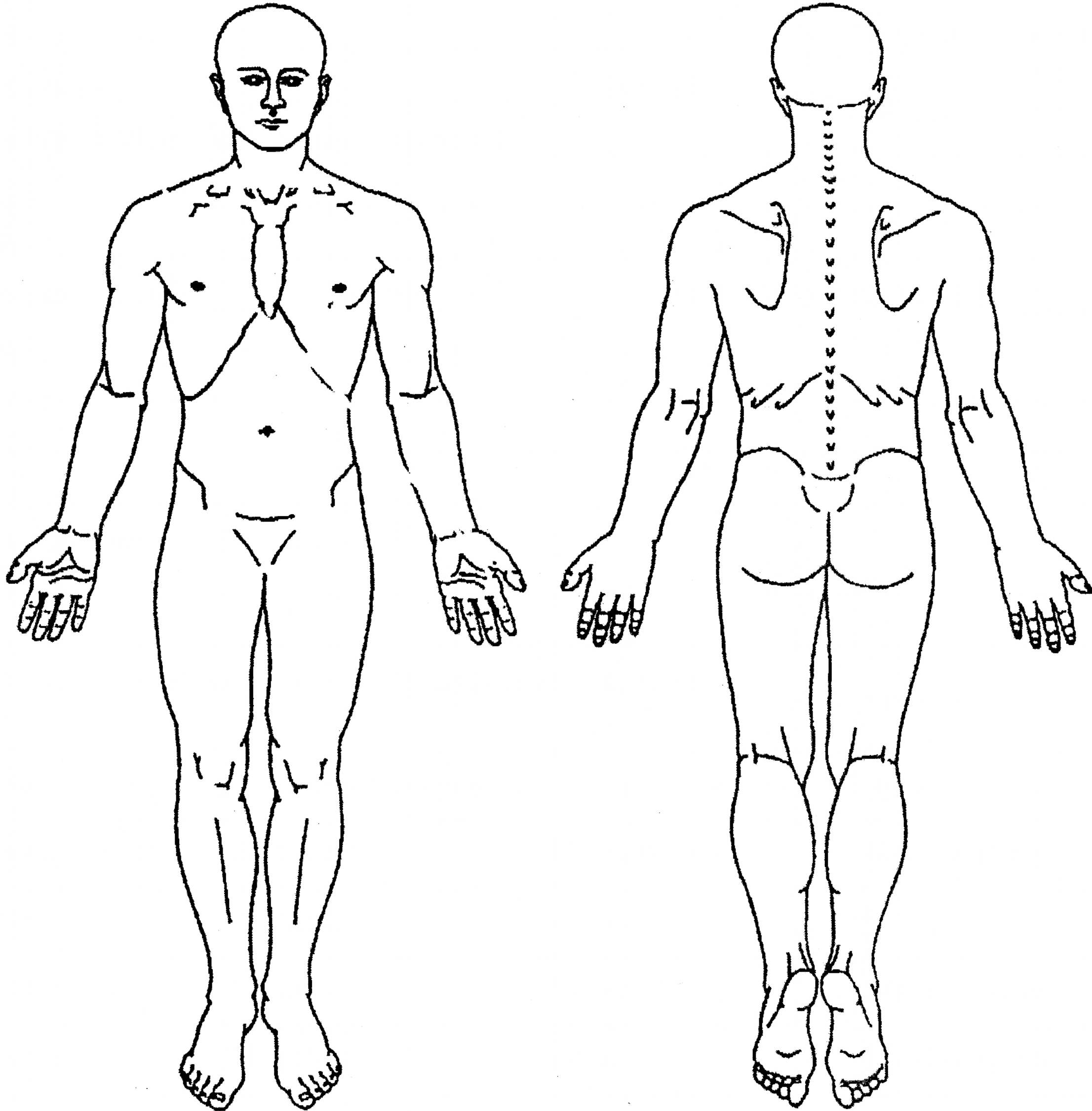
____

____

____

Please circle areas of concern and mark with
P *for Painful,* ***N*** *for Numbness or tingling,* ***W*** *for Weakness and* ***S*** *for Scars*



DISCLOSURE & CONSENT

Please thoroughly read the following paragraphs and then initial each paragraph after reading.

______ I understand that the CranioSacral therapist does not diagnose illness, disease or any other physical or mental disorder. In addition, the CranioSacral therapist does not prescribe medical treatment or pharmaceuticals.

______ I understand that CranioSacral therapy is considered to be a contraindication for recent injuries to the head and neck, i.e.; recent whiplash, any recent fracture to the base of the neck, concussion, hemorrage, as well as rheumatoid arthritis, and state that I am not currently experiencing any of these conditions.

______ It has been made very clear to me that CranioSacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

______ Because a CranioSacral therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take upon myself to keep the CranioSacral therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

I have completed the above information accurately and have read, understand and take responsibility for the above statements.

Signature ____ Date ____________

Thank you for your cooperation!

CANCELLATION POLICY

I understand that each appointment I have scheduled is very important, either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Sarah-Jane O'Neil within 24 hours if I need to cancel an appointment. If I am unable to do this I understand that I will be responsible for payment for the schedule time unless Sarah-Jane is able to fill the appointment time.

I have read and understand this cancellation policy.

Name ____ Date ____________