Center for Health and Wellness

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Client Information Form - CranioSacral Therapy

CONFIDENTIALITY: All information on this questionnaire will be kept strictly confidential.

Name: _____ E-mail _____

Address: _____ City _____ State _____ Zip _____

Phone (best way to reach you): ❑ (Home) _____ ❑ (Cell) _____ ❑ (Other) _____

Age: _____ Birth Date: _____

Occupation: _____

Referred by: _____

Emergency contact person: _____ Phone: _____

❑ Yes ❑ No Have you previously experienced CranioSacral Therapy?

❑ Yes ❑ No Are you currently under a physician's care for any condition? Please describe: _____

_____

Physician's name: _____ Phone: _____ Fax: _____

Primary reason for today's visit, (please explain): _____

_____

Areas of complaint, pain, tension, (please explain): _____

_____

In a few words, please describe your goal for this session: _____

_____

Are you aware of any emotional distress from the time of an injury?: _____

_____

Have you suffered any form of abuse your body may be holding?: _____

_____

Please answer the following questions:

❑ Yes ❑ No Do you wear contact lenses?

❑ Yes ❑ No Do you wear dentures?

❑ Yes ❑ No Have you had extensive dental work (ie; braces, etc.)?

❑ Yes ❑ No Car accident (at any time), serious falls or injuries?

❑ Yes ❑ No Do you have any allergies? If so, please describe allergens:

_____

❑ Yes ❑ No Do you have arthritis? What type and where? Please describe: _____

_____

❑ Yes ❑ No Do you have any heart problems? Please describe: _____

_____

❑ Yes ❑ No Do you have any spinal problems? Please describe: _____

_____

❑ Yes ❑ No Are you presently pregnant? How far along? Complications? _____

_____

❑ Yes ❑ No Have you had surgery? How recently? Complications? _____

_____

❑ Yes ❑ No Do you take any prescribed medications? Please list: _____

_____

❑ Yes ❑ No Do you exercise or play sports on a regular basis? Please describe: _____

_____

❑ Yes ❑ No Are you receiving any other complementary care currently, (chiropractor, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? If so, please describe:

_____

❑ Yes ❑ No Do you have any other physical or mental condition of which I should be aware before giving you a CranioSacral session? If yes, please describe: _____

_____

Please read and initial:

____ 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, ie; recent whiplash, any recent fracture to base of the neck, concussion, hemmorage, 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 it 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.

Signature: _____ Date: _____

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

Therapist notes: