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Client Information Form - CranioSacral Therapy

ll information on this questionAnaire will be kept strictly confidential.

Name: ______________________ E-mail ____________

Address: ______________________ City ____________ State _____ Zip ________

Phone (best way to reach you): ☐ (Home) ____________ ☐ (Cell) ____________ ☐ (Other) ____________

Age: _____ Birth Date: ______________________ *(Required for insurance billing)*

Occupation: ______________________

Referred by: ______________________

Emergency contact person: ______________________ Phone: ____________

☐ Yes ☐ No Have you previously experienced Cranio Sacral 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 Cranio Sacral session? If yes, please describe: ______________________________

____

Please read and initial:

____ I understand that the Cranio Sacral therapist does not diagnose illness, disease, or any other physical or mental disorder. In addition, the Cranio Sacral 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 cranio Sacral 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 Cranio Sacral therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Cranio Sacral 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: