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CranioSacral Therapy Client Information - ADULT

Name ____________________________________ Today's Date ________________
Street Address ______________________________ Date of Birth ________________
City __________________________________ State _____ Zip ______________
Home Phone ________________ Work Phone ______________ Cell Phone ___________________
Occupation ____________________________ Email address: ________________________________
Referred by: ____________________ Emergency Contact & Phone ____________________________
Please describe why you've come for treatment & physical, mental, emotional symptoms you're having:
____
____
Any accidents, injuries, or surgeries? Anesthesia? No ____ Yes ____
If yes: ____
____

Health History:

____ recent dental work
____ orthodontia/braces
____ TMJ problems
____ headaches
____ mouth breather ___day ___ night
____ snore ____ wake up at night _____
____ high level of stress
____ digestive problems
____ high blood pressure
____ asthma or respiratory problems
____ cancer
____ diabetes
____ currently pregnant
____ addictions: ___alcohol __ drugs __ food
____ heart problems
____ other _______________________

Please list prescription drugs you currently take: ____

Birth and Infancy History (What your parents may have told you):

____ Caesarian delivery?
____ Breast fed or ____ Bottle fed?
____ Frequent illnesses?
____ Forceps or vacuum suction delivery?
____ Ear inflammations/infections?
____ Vaccinations? ____________________

Exercise level: ____ active ____ moderate ____ light ____ no exercise
Nutritional habits: # vegetables per day ______ # fruits per day ______ whole grains ______
meat & chicken? ______ fish? ________ WATER:oz. per day?__________ supplements? __________
Allergies? ____
Have you ever had CranioSacral Therapy? ____
What do you hope to achieve? ____
What other treatments have you received? ____
Other symptoms or conditions that you want me to be aware of? ______________________________

Signature:______________________________