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CranioSacral Therapy Client Information - CHILD

Name _____ Birthdate _____ Age _____ Today's Date _____
Street Address _____ City _____ State _____ Zip _____
Mother's Name _____ Father's Name _____
Mother's Work Phone _____ Father's Work Phone _____
Home Phone _____ Cell Phone _____Referred by: _____
Reason for bringing your child for CranioSacral Therapy? (Please include any physical, mental, emotional symptoms your child is having:) _____

_____

_____ Email: _____
Any accidents, injuries, or surgeries? No ____ Yes ____
If yes: _____-

Birth and Infancy History:

____ Caesarian delivery?
___ Labor difficulties?_____
____ Breast fed or ____ Bottle fed?
____ Severe colic or sucking problems?_____
____ Ear inflammations/infections?
___ Forceps or vacuum suction delivery?
____ Anesthesia/epidural? _____
____ Vaccinations? _____
____ Pacifier use? How long? _____
____ Frequent illnesses? _____

Health History:

____ recent dental work
____ orthodontia/braces
____ TMJ problems
____ headaches
____ mouth breather ___day ___ night
____ snores
____ allergies _____
____ sleeps through the night
____ bed wetter
____ asthma or respiratory problems
____ specific medical condition?_____
____ childhood illnesses
____ other _____

School situation: Please describe your child's experience at school. Able to focus? Fidgety? Has friends?, etc.

_____

_____

Personal habits: Television? Hours/week _____ Computer/Video Games? Hours/week _____
Movies/videos? Hours/week _____ Bedtime at ____pm Wakes up at _____am Hours of sleep _____
Does your child exercise regularly? _____
Nutritional habits: # vegetables per day _____ # fruits per day _____ whole grains _____
meat & chicken? _____ fish? _____ Water: :oz. per day?_____ supplements? _____
Has your child had CranioSacral Therapy? _____Any other treatments? _____

As the parent of a minor child, your signature below signifies your authorization for his/her treatment:

Signature:_____