Craniosacral Therapy Intake Form

(Use this form when Craniosacral Therapy is the only session choice)

Name:_____Date of Birth: _____

Address:_____City:_____State:_____Zip:_____

Preferred Contact Method:_____(cell) (work) (email) Occupation:

_____Number of years: _____

Referred by: _____

Emergency Contact:_____Phone: _____

Have you experienced Craniosacral Therapy before? Yes_____No_____

Are you concerned with an increase in cranial pressure? Yes_____No _____

Are you currently under the care of a physician for any condition? Yes_____No_____ If yes, please describe: _____

_____.

Physician's name:_____Phone: _____

Primary reason for today's visit: (Please explain.) _____

_____

_____.

Areas of concern, pain or tension: (Please explain.) _____

_____

_____

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

_____.

Are you aware of any emotional distress from an injury or trauma? (Please explain.) _____

_____

_____

_____.

Have you suffered any form of abuse your body may be holding? (Please explain as much as you are comfortable doing, keeping in mind everything here is held in strict confidence.) _____

_____

_____.

Please answer the following questions:

Do you wear contact lenses? Yes_____No_____

Do you wear dentures? Yes_____No _____

Have you had extensive dental work (i.e. braces, crowns, root canals, scraping, etc.)? Yes_____No _____

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Car accident (at any time in your life)? Yes_____No_____
Serious falls or injuries? Yes_____No _____
Head injuries? Yes_____No _____
If you answered yes to any of the above, please explain: _____
_____
_____.

Do you have allergies? Yes_____No_____If yes, please explain: _____
_____.
Do you have arthritis? Yes_____No_____ If yes, what type and what areas of your body has it affected?
_____.

Do you have heart related problems (heart disease, heart transplant, atherosclerosis, etc.)?
If yes, please describe: _____
_____.

Do you have spinal problems? Yes_____No_____ If yes, please describe: _____
_____.

Do you have cervical problems? Yes_____No_____If yes, please describe: _____
_____.
Have you had any surgeries? Yes_____No_____ If yes, please explain and provide date: _____
_____
_____.

Have you been diagnosed with or had an aneurysm? Yes_____No _____

Are you pregnant? Yes_____No_____ If yes, how may weeks?_____.

Please circle the most appropriate answer. I have high, extended stress days.
I have medium stress days that are well tolerated.
I have low stress days.

Do you take prescription medication? Yes_____No_____ If yes, please list by name and dosage: _____
_____
_____.
Do you take supplements? Yes_____No_____ If yes, please list by name and dosage: _____
_____
_____.

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Are you currently receiving any other complementary care (chiropractor, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy, etc.)? Yes_____No _____

Do you have any other physical or mental condition of which I should be aware of before you receive a Craniosacral Therapy session? Yes_____No_____If yes, please explain: _____

_____

_____.

Please read and initial:

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

_____I am not currently experiencing any of these conditions: (within the last 6 months) injury to the head and/or neck; any fracture to the base of the neck, concussion, hemorrhage, or rheumatoid arthritis.

_____I am aware that Craniosacral therapy is not a substitute for medical examination and/or diagnosis and that it is recommended I see a physician for any physical ailment I might have.

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

Client's signature_____Date:_____

Guardian's signature_____Date:_____

Therapist's signature_____Date: _____

Therapist's Notes:

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