Welcome! Please take a few moments to fill out this form. If you have any questions, I'll be glad to help you. I look forward to working with you!

Client Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Sex: M F Birth Date _____ Marital Status _____

Email: _____

Employer _____ Occupation _____

Referred by: _____

Emergency Contact Name:_____

Phone: Home _____ Work _____

Reason for Visit

Have you ever had CranioSacral Therapy before? _____ Date of last session _____

Your reason for today's visit: _____

Are your symptoms: Mild ————————-Moderate —-———— Severe

What do you believe to be the cause of this condition? _____

Have you ever had similar symptoms in the past? _____ When? _____

What goals do you have in mind for today's session? _____

Health History

In the past 10 years, please list the following with dates of occurrence:

Injuries: _____

Surgeries: _____

Major Illnesses: _____

Accidents/Injuries: _____

Cancer: _____

Other Health Challenges: _____

Have you ever in your life had an Infectious Disease? Yes _____ No _____ If yes, please give specifics (type, treatment, current health status, etc.)_____

_____

OVER

Please list all medications, supplements, herbs or other substances you're taking:_____

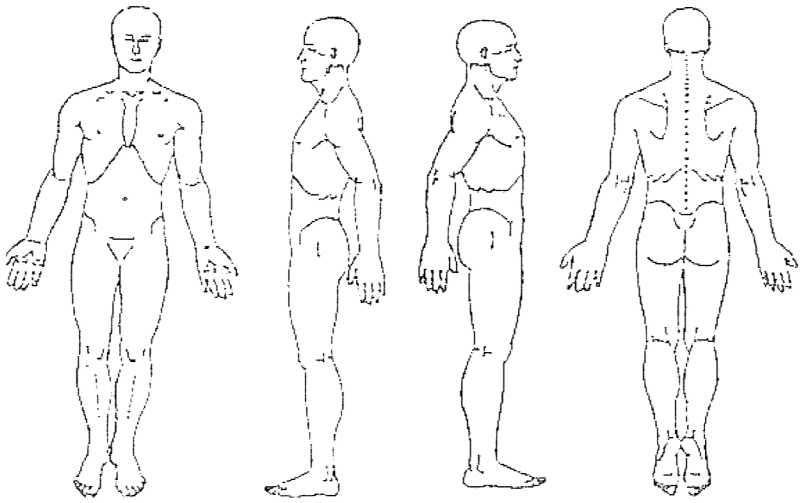
_____

Intake Per Day	None	Light	Moderate	Heavy
Water	____	____	____	____
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____
Exercise	____	____	____	____
Appetite	____	____	____	____

How many hours of sleep do you get each night? _____

How many bowel movements do you have a week? _____

Legend:
Pain = X
Numbness = O
Stiffness = //



I understand CranioSacral Therapy is not a substitute for medical exam, diagnosis, or treatment, nor is it intended to diagnose, prescribe, or treat any physical/mental illness, and that nothing said or done in the course of the session given is intended as such. I agree to list all my known medical conditions, and answer all questions completely and honestly, and will give a complete update of changes in my medical profile or prescription medications. I hereby release Sandra Schell from any and all liability for any harm which may be occasioned by me. **I understand and agree to be responsible for the full fee for any appointment rescheduled or canceled with less than 48-hour notice via phone call. I understand full payment is due at the end of each session.** Late arrivals will be given the remaining time in their session. I have reviewed the information on this questionnaire and it is complete and accurate to the best of my knowledge.

Signature _____ Date _____