NEW CLIENT INTAKE FORM

~FOR CONFIDENTIAL USE ONLY ~

Welcome! I would like to make our sessions as therapeutic and attuned to your needs and history as much as possible. Please provide the information below. If you have any questions, please let me know.

Name:_____ DOB: _____ Today's date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Email: _____

Occupation: _____ Employer: _____

Have you ever received Craniosacral Therapy? _____ Massage? _____

Other bodywork/therapies/modalities experienced? _____

What is the reason for your visit today?

_____

Are you currently taking any medications? _____ If yes, please list name and reason for medication:

_____

_____

Are you currently seeing any other healthcare professionals? _____ If yes, please list names, and reason and/or treatment:

_____

_____

Please review this list and check those conditions that have affected your health either recently or on the past:

_____ arthritis

_____ diabetes Type: _____

_____ blood clots

_____ broken/dislocated bones

_____ bruise easily

_____ cancer Type: _____

_____ chronic pain Where: _____

_____ constipation/ diarrhea

_____ autoimmune condition

_____ hepatitis Type: _____

_____ skin conditions Type: _____

_____ stroke

_____ surgery Type: _____

_____ seizure

_____ nausea/ gastric issues

_____ other: _____

_____ dementia/ memory loss

_____ fibromyalgia

_____ depression, panic disorder

_____ post-traumatic stress

_____ accidents/ injuries

_____ birth trauma

_____ whiplash

_____ frequent headaches/ migraines

_____ heart conditions Type: _____

_____ back problems

_____ H/L blood pressure

_____ insomnia

_____ muscle strain/sprain

_____ pregnancy

_____ scoliosis

_____ stress

_____ varicose veins

_____ chemical or other dependency

_____ HIV, herpes

_____ chronic fatigue

Please provide any necessary details to the conditions checked above:

_____

_____Do you smoke? Cigarettes Marijuana Pipe Other Frequency? _____

Do you drink alcohol? _____ Frequency? _____ Do you drink caffeine beverages? _____ Freq? _____

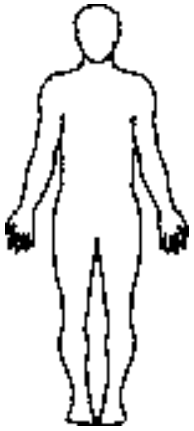
Do you use recreational drugs? _____ Type: _____ Frequency? _____

Do you exercise? _____ How often? _____ Activities? _____

Do you have any allergies? _____ Please list: _____

Are you possibly pregnant? _____

Please indicate with an "X" the areas, if any, in which you are feeling discomfort:



Front

Back

What are your goals/expectations for our therapy sessions together:

_____

_____

_____

Please read the following information, initial each line, and sign below:

_____ 1. I understand that the following may occur during the therapy session (somato-emotional release, an increase in localized pain, emotional tension, trigger of anger, past memories, sleepiness, fatigue, detoxification, lymphatic drainage, energy shifts, twitching of body parts) and are part of a normal response to releasing held energies and a deeper healing process.

_____ 2. I understand that although craniosacral and massage therapies can very therapeutic and relaxing, it is not a substitute for medical examination, diagnosis, and treatment.

_____ 3. This is a therapeutic session, and any sexual advances or remarks will terminate the session and the client will remain financially responsible to pay for the session.

_____ 4. I understand that there is a 24 hour cancellation policy, and that I will responsible for full payment of the scheduled session if I cancel less than 24 hours from the scheduled appointment time.

_____ 5. I affirm that I have answered all the questions pertaining to medical and psychological health conditions truthfully.

Client Signature Date