Biodynamic Craniosacral Therapy Client Intake Form

Name_____ Date: _____

Address_____
Street City State Zip

Date of Birth _____

Home Number _____ Cell Number_____

Emergency Contact
_____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain:

Have you had a recent major surgical procedure or injury? ____ Yes ____ No

Please Explain:

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

____ Yes ____No

Please Explain:

✔the following conditions that apply to you. Please add your comments to clarify the condition.

☐Headaches/Migraine
☐ Sleep
☐Nausea/ vomiting
☐Dizzy/fainting
☐Ears
☐Eyes
☐Mouth/teeth
☐Jaw
☐Sinus
☐Neck pain
☐Back pain
☐Shoulders
☐Arm/hand
☐Feet
☐Leg/hip
☐Joints
☐Epilepsy
☐Bowels
☐Bladder
☐Skin rashes
☐Bruising/ swelling
☐ Lungs
☐Stomach
☐ Allergies
☐ Liver
☐Hernias
☐Asthma
☐Gallbladder
☐Weight changes
☐ Indigestion/Stomach
☐Heart burn
☐ Female problem
☐Male problems
☐ Smoking/Drugs
☐ Energy levels
☐Cold
☐numbness
☐ Blood pressure
☐Heart Attack
☐pain Stroke
☐Stress levels Please circle your stress level:Low 1 2 3 4 5 High

MEDICATIONS/SUPPLIMENTS:

SIGNIFICANT FAMILY MEDICAL HISTORY:

ACCIDENTS/SURGERY/MEDICAL HISTORY:

REASON FOR THE VISIT:

I understand that a Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation.
I acknowledge that any information and or photos, collected as part of my notes, remains private and confidential. Only the therapist treating me will have access to this information.

Client's signature_____Date_____

Name of client:

Name of Guardian:

Relationship to client: Signature of Guardian: