CRANIAL SACRAL THERAPY CASE HISTORY FORM

Name _____ Date of Birth _____

(month / day / year)

Address _____ Family Doctor_____

Postal Code_____ Phone_____

Phone (home) _____

(cell) _____

(work) _____

Email_____

(email is for automatic email appointment confirmations and 2-day reminders)

Occupation_____ Care card #_____

Do you currently have an active ICBC or WBC claim Yes_____No_____claim #_____

How did you hear about this clinic?_____

- Reason for treatment:_____

_____

- Date of onset:_____
- Symptoms:_____

_____

- Has this condition occurred before?

No___Yes_____

Are you currently taking any medications for any reason?_____

_____

Are you currently seeing another practitioner for any reason?_____

No_____Yes_____

- Are you satisfied with your:

Ability to relax	yes	no
Sleep	yes	no
Overall health	yes	no
Exercise	yes	no
Energy level	yes	no

-
- Please list all dental work performed (excluding fillings & cleanings):_____

_____

PERSONAL MEDICAL HISTORY

P = PAST – C = CURRENT

CHILDHOOD:

Birth Trauma __
Feeding problems __
Colic __
Recurrent ear infections __
Developmental delays __
Hyperactivity/ADD/ADHD __
Learning disabilities __
Eye motor problems __

HEAD & SPINE:

Head Injury __
Spinal Injury __
Headaches __
Migraines __
Jaw pain __
Whiplash __
Fainting/dizziness __
Ringing in ears __
Sinus problems __

CARDIOVASULAR:

Heart Condition __
Stroke __
High/low Blood pressure __
Pacemaker etc. __
Arteriosclerosis __
Cardiovascular aneurysm __
Phlebitis or Varicose Veins __

RESPIRATORY:

Shortness of breath __
Bronchitis __
Asthma __
Emphysema __

GASTROINTESTINAL

Heartburn __
Nausea __
Gas __
Constipation/Diarrhea __
Ulcer __

OTHER:

Arthritis __
Infections __
Susceptible to cold/illness __
Insomnia __
Fatigue __
Skin Conditions __
Pregnancy __
Cancer __
Epilepsy/Seizures __
Diabetes __
Hepatitis __
Kidney condition __
Contagious conditions __
Other_____

HISTORY OF TRAUMA: please list all accidents, injuries, surgeries, big falls, blows to the head?

_____
_____
_____

- Is there anything else that your therapist should know?

_____
_____
_____

Please note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or you will be responsible for the full appointment fee. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee.

Signature:_____ Date:_____