

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 the time of 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 confidentiality) _____

_____.

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 ____



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: _____

Have you had any of the following: brain hemorrhage or stroke, bleeding on the brain, spinal tap or puncture in the craniosacral system? If yes, please describe and when: _____

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: _____

Are you pregnant? Yes ___ No ___ If yes, how many 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: _____



Do you or have you had any of the following conditions:
 Arnold Chiari Malformation? Yes ___ No ___ If yes, please describe any treatment (past, present or ongoing) for this condition: _____

 Recent fracture of the skull bones, vertebral column or ribs? Yes ___ No ___ If yes, please describe any treatment (past, present or ongoing) for this condition: _____

Are you currently receiving any other complementary care (chiropractor, naturpathic, 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: recent (within the last 6 months) injury to the head and/or neck; any recent 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:

