CRANIOSACRAL THERAPY - CLIENT INTAKE FORM

87 Bridge Street West,
Bancroft, ON K0L 1C0

416 837-0031
troymillerrmt@gmail.com

Name _____

Phone Number _____

Email _____ Address _____ Date of Birth _____

Emergency Contact _____ City _____ Occupation _____

Phone _____ Province _____ Postal Code _____

MEDICAL INFORMATION

Do you CURRENTLY have any of the following conditions, illnesses or problems?

Heart Condition	Y❑ N❑	Hemophilia	Y❑ N❑	Pain, numbness, tingling in limbs	Y❑ N❑
High/Low BP	Y❑ N❑	Phlebitis	Y❑ N❑	Chronic bodily discomfort	Y❑ N❑
Headaches	Y❑ N❑	Respiratory Problems	Y❑ N❑	Chest pain during exertion	Y❑ N❑
Diabetes	Y❑ N❑	Elimination Problems	Y❑ N❑	Excessive tiredness/fatigue	Y❑ N❑
Cancer	Y❑ N❑	Circulatory Problems	Y❑ N❑	Illness or injury at the present time	Y❑ N❑
Convulsions	Y❑ N❑	Digestive Problems	Y❑ N❑	Contact Lenses	Y❑ N❑
Thyroid Problems	Y❑ N❑	Eye, ear, nose, throat disorders	Y❑ N❑	Dentures, Removable Bridge, Braces	Y❑ N❑
Osteoporosis	Y❑ N❑	Contagious or communicable disorders	Y❑ N❑	Currently Pregnant	Y❑ N❑
Arthritis	Y❑ N❑	Disability of feet, ankles, knees, hips, back	Y❑ N❑		

Any relevant health issues, past injuries, traumas, accidents, surgeries, and or serious illnesses? (Need additional space? Use back of sheet)

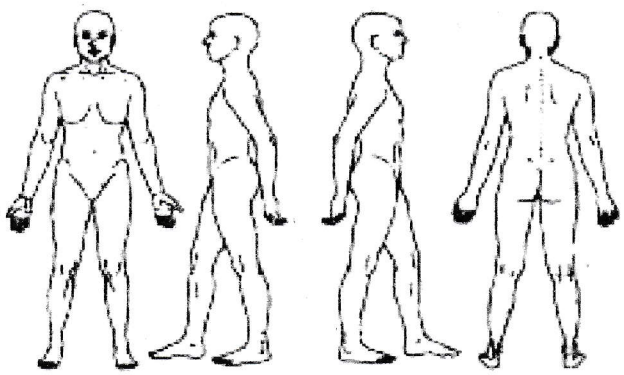
Dates _____ Area(s) affected _____ Treatment(s) _____

Describe your relationship with your body? _____

Describe your relationship with your feelings and emotions?

What are the main stressors in your life?

Are you currently under the care of other health care providers?



Circle any specific areas that are of concern.

AUTHORIZATION: To the best of my knowledge, the above information is complete and accurate. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that i may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health. I understand that these therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that these therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I acknowledge that any information I receive from individuals performing therapy is educational in nature and is to be used at my own discretion.

Please understand that there is a 24 hour cancellation fee in effect and that a missed appointment fee of $40 will be applied if no conatct has been made to the therapist. Your missed appointment affects the therapists time and bottom-line.

Signature _____ Date _____