

Ease, Joy and Alchemy, LLC
CRANIOSACRAL THERAPY NEW CLIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____ Birth Date _____

Family – Spouse/Partner, Kids, Creatures? _____

Email Address _____ May we add you to my mailing list? _____

Best Phone to Contact _____ C-W-H? Alternative Contact # _____

Emergency Contact – Name _____ Phone# _____

How did you learn about us? _____

If it was a personal referral, may we thank them for their referral? _____

Have you received Professional Massage Therapy or Bodywork before? _____

What Kinds? _____ How often? _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Contagious Conditions |
| <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Muscle Sprain / Strain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Heart Attack / Stroke |
| <input type="checkbox"/> Allergy to Nut Oils | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Headaches or Migraines |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Pelvic injury |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Skin Infections | <input type="checkbox"/> Other Conditions |
| <input type="checkbox"/> Hypo or Hyperglycemia | |

Please list and explain other conditions/symptoms you are or have experienced: _____

Have you had any serious or chronic illness, operations, or traumatic accidents? _____

If yes, please give dates and details: _____

OVER PLEASE

Are you currently, or have you at any time within the last 12 months been under the care of a physician? If so, for what condition? _____

Are you on any medication? _____

If yes, which ones and for what condition? _____

If appropriate, and with your knowledge, may I have permission to contact your Doctor / Therapist? _____

Doctor / Therapist Name: _____ Telephone _____

Lifestyle choices

What forms of exercise to you enjoy regularly and how often ?

Do you drink caffeinated beverages? _____

Do you smoke cigarettes? _____

Do you consume alcohol? _____

I have completed this health form to the best of my knowledge. I understand that CranioSacral Therapy services are a therapeutic health aid. They do not take the place of a physician's care when indicated. Any information exchanged during a session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 notice, I agree pay any missed appointment charge applicable.

Signature _____ Date _____

If a minor, signature of Parent/Guardian is required:

Signature _____ Date _____