CLIENT INFORMATION

FULL NAME:_____ DOB:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

CELL PHONE:_____ HOME PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____

EMAIL:_____ OCCUPATION:_____

REFERRED BY: _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

ARE YOU UNDER CHIROPRACTIC CARE? IF YES, DOCTOR/CLINIC _____

MEDICATIONS:_____

LIST IN ORDER OF MOST IMPORTANT TO LEAST IMPORTANT AREAS OF PAIN OR DYSFUNCTION YOU FEEL ARE PRESENT IN YOUR BODY:

1._____

2._____

3._____

HAVE YOU SEEN A GENERAL PRACTITIONER OR SPECIALIST FOR ANY OF THESE PROBLEMS? YES/NO

_____

WAS THERE ANY TREATMENT OR DIAGNOSIS GIVEN? YES/NO

_____

HAS THE CONDITION CHANGED WITH TREATMENT?

_____

_____

_____

CIRCLE ANY AREAS THAT CURRENTLY APPLY – MARK A LETTER (P) FOR PAST ISSUE

INCREASED INTRACRANIAL PRESSURE ACUTE STROKE CEREBRAL ANEURYSM HEMORRHAE

HERNIATED MEDULLA OBLONGATA RECENT SKULL FRACTURE CEREBROSPINAL FLUID LEAK

SPINA BIFIDA (MYELOMENINGOCELE) ARNOLD CHIARI MALFORMATION

MEDICAL HISTORY CONTINUED

CIRCLE ANY AREAS THAT CURRENTLY APPLY – MARK A LETTER (P) FOR PAST ISSUE

MUSCULOSKELETAL SYSTEM

LOW BACK PAIN	MID BACK PAIN	NECK PAIN
ARM PAIN	LEG PAIN	JOINT PAIN
CARTILAGE TEARS	CONSTANT JOINT STIFFNESS/ACHE	DIFFICULTY WALKING
BROKEN BONES	SHOULDER PAIN	MUSCLE STRAINS
TORN MUSCLES	LIGAMENT SPRAINS	ARTHRITIS

NERVOUS SYSTEM

NUMBNESS/TINGLING	DIZZINESS OR VERTIGO	LOSS OF BALANCE
FREQUENT HEADACHES OR MIGRAINS	FAINTING	LOSS OF COORDINATION
HEARING PROBLEMS	SEIZURES	
FREQUENT MUSCLE TWITCHING, TICS OR SPASMS		

MOUTH, THROAT, NECK

TROUBLE SWALLOWING	DENTAL CROWNS, BRIDGES, MOUTH WORK	
BRACES (CURRENT OR HISTORY)	GRINDING OF TEETH, TMJ, CLICKING JAW	

RESPIRATORY SYSTEM

ASTHMA	CHRONIC/FREQUENT COUGHING	PAIN ON BREATHING
REGULAR COLDS OR INFECTIONS	FREQUENT SHORTNESS OF BREATH	

CARDIOVASCULAR SYSTEM AND PERIPHERAL VASCULAR SYSTEM

HIGH/LOW BLOOD PRESSURE	HEART MURMURS	HEART PALPITATIONS
VARICOSE VEINS	IRREGULAR HEART BEAT	ANEMIA

GASTROINTESTINAL SYSTEM

FREQUENT CONSTIPATION	FREQUENT DIARRHEA	FREQUENT CRAMPS
ABDOMINAL PAIN	FREQUENT INDIGESTION OR GAS	FREQUENT HEARBURN
COLITIS, CRON'S DISEASE, OR ULCERS		

REPRODUCTIVE SYSTEM

FREQUENT CRAMPING	PREGNANCY	C-SECTION
IRREGULAR CYCLE	FIBROIDS, CYSTS, OR ENDOMETRIOSIS	
MENOPAUSE OR PERI-MENOPAUSAL SYMPTOMS		

ARE YOU PREGNANT?

ARE YOU PREGNANT? YES ____ NO ____ IF YES, PLEASE ANSWER THE FOLLOWING:

OF WEEKS PREGNANT_____

DUE DATE: _____

HAVE YOU EVER HAD A PREGNANCY MASSAGE? YES ____ NO ____ IF YES, WHEN? _____

DOCTOR'S NAME/CITY: _____

ANY PROBLEMS OR ISSUES WITH YOUR PREGNANCY?

_____

_____

CONSENT FOR TREATMENT

I _____ REQUEST AND CONSENT TO CRANIOSACRAL THERAPY TREATMENT FROM DIANA WOZNIAK. I UNDERSTAND THAT CRANIOSACRAL THERAPY REQUIRES PHYSICAL CONTACT WITH MY BODY. I UNDERSTAND THAT THE PARTICULAR THERAPEUTIC OUTCOMES OF THESE TREATMENTS CANNOT BE PREDICTED WITH CERTAINTY AND NO GUARANTEE CAN BE MADE REGARDING ANY PARTICULAR RESULT OR OUTCOME. I UNDERSTAND THAT A SERIES OF SESSIONS IS RECOMMENDED FOR OPTIMAL RESULTS. I CERTIFY THAT ALL MEDICAL AND SOCIAL INFORMATION ON THE INTAKE FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required. Because massage/bodywork may be contraindicated for certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand massage therapists and bodyworkers are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. I understand cancellations made with less than 24 hour notice, late arrivals, and no-shows will be liable for a $25 fee.

CLIENT SIGNATURE: _____ DATE:_____

WITNESS SIGNATURE: _____ DATE: _____