Supporting the healing process with

CranioSacral Therapy , Somatic Experiencing,
and Aquatic Bodywork

Client Information:

NAME:_____

PRONOUNS:_____ DATE OF BIRTH:_____

PHONE- (Best place to reach you) : _____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

EMAIL ADDRESS: _____

(CIRCLE ONE): SINGLE WIDOWED DIVORCED HAVE A SPOUSE or PARTNER

NAME OF SPOUSE OR PARTNER:_____

EMERGENCY CONTACT: _____

HOW DID YOU HEAR ABOUT US:_____

Describe the reason you have come here and the symptoms you are experiencing:

_____

_____

_____

_____

Date of injury or onset of symptoms: _____

What makes the symptoms worse: _____

What makes the symptoms better: _____

(Please continue to next page)

What other treatments have you received for this problem: _____

_____

_____

List your top 3 goals for therapy in order of priority:_____

_____

_____

_____

List all prescription and non-prescription medications you are currently taking: _____

_____

List any allergies that you have: _____

_____

List and date surgeries/hospitalizations, car accidents, or work injuries_____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

Payment is required at the time of service and you are responsible for all fees.

Please provide 24 hours cancellation notice if you are unable to keep your appointment.
If we are not notified 24 hours in advance, we will charge you for your missed appointment.

MY SIGNATURE CONFIRMS THAT I AM AWARE OF AND AGREE TO THE ABOVE.

SIGNATURE:_____DATE:_____