Supporting the healing process with

CranioSacral Therapy and Aquatic Bodywork

Client Information:

NAME:_____DATE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE- (Best place to reach you) : _____

EMAIL ADDRESS: _____

DATE OF BIRTH:_____ MALE:_____ FEMALE:_____

(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 illness: _____

What makes the problem worse: _____

What makes the problem better: _____

What other treatments have you received for this problem: _____

_____

_____

(Please continue to next page)

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

_____

List any allergies that you have: _____

_____

List and date surgeries/hospitalizations: _____

_____

_____

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:_____

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IF THE PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

NAME OF & PHONE OF LEGAL PARENTS OR GUARDIAN:

_____

SIGNATURE:_____DATE:_____