CRANIOSACRAL THERAPY

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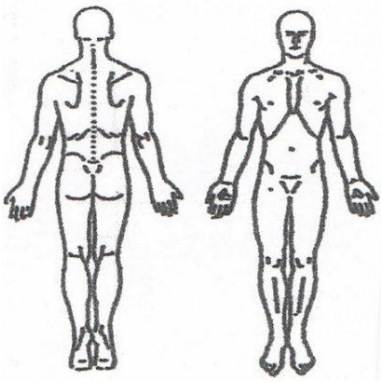
INTAKE FORM

Name_____ Phone_____
Parent Name (for minor)_____
Address_____ Date_____
Email_____ referred by_____
DOB_____

Surgeries_____
Accidents_____
Severe illness/Medical Condition_____
Allergies_____
Medications_____
_____

Do you have physical symptoms that cause discomfort?
Please mark areas of concern and explain.

_____
_____
_____
_____
_____
_____
_____



What benefits would you like to receive from CranioSacral Therapy?_____
_____

What therapies have you utilized so far?_____

Do you feel there is an emotional component to your physical symptoms?_____
_____

How would you describe your current stress levels, and what tools do you have for coping with stress?_____
_____

<u>Pediatric Clients Only</u>

Describe pregnancy (complications)_____
_____
Describe child's birth (type, duration, complications)_____
_____
Feeding Issues_____
_____