CRANIOSACRAL THERAPY INTAKE FORM

Send completed form by email to lmanning@chesapeakeholistic.com or fax to 410-757-6742 – before your FIRST appointment, to enable effective time-scheduling for your session and others. (Please use back of page if needed to complete answers.)

Name: _____ Referred By: _____

Occupation: _____ Email: _____ Date: _____

What is your treatment goal? _____

☐ Yes ☐ No Are you under the care of any healthcare professionals? If so, please explain:

_____

☐ Yes ☐ No Are you currently taking medications or supplements? If so, please list:

_____

☐ Yes ☐ No Have you had any accidents/falls? If so, explain (include dates):

_____

☐ Yes ☐ No Have you had any surgeries/hospitalizations? If so, explain (include dates):

_____

☐ Yes ☐ No Have you had any head, neck or back injuries? If so, please list:

_____

☐ Yes ☐ No Have you ever suffered from frequent headaches? If so, explain:

_____

☐ Yes ☐ No Do you suffer from stress? If so, explain (recent/chronic):

_____

Briefly detail any traumatic occurrences in your life (death of family/friends, accidents, attack, etc.):

_____

Please explain any other health issues/concerns you have:

_____

CONSENT TO TREAT

I have informed my massage therapist/bodywork practitioner of all known physical and medical conditions, and medications (including herbal remedies/supplements). I will update the practitioner about any changes. I am aware a bodywork therapist does not diagnose illness/disease or prescribe medications, and chiropractic spinal adjustments are not part of Craniosacral and Myofascial Release therapy.

Signature: _____