New Patient Craniosacral Therapy

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your needs, exclude any techniques that may be medically unsuitable for you, and may be used, while protecting your privacy.

Name_____ **Date of Birth**_____ Male Female

Address_____**City/State/Zip**_____

Phone (H)_____**(C)**_____Occupation_____

Referred By: _____ Emergency Contact & Phone: _____

E-mail_____ Have you been seen at Knewtson Health Group before? Yes ☐ No ☐

Current Medications/OTC/Supplements & WHY: _____

_____

Please answer the following to the best of your knowledge.

1.. Have you had a professional craniosacral (CST) session before? Yes No

2. Do you have any particular goals for this CST session? _____

3. If you are currently under medical supervision, please explain_____

4. Please check any condition/symptom listed below that applies to you:

Musculoskeletal System
- ☐ Artificial Joint
- ☐ Baker's Cyst
- ☐ Bursitis
- ☐ Fibromyalgia or CFS
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoperosis
- ☐ Plantar Fasciitis
- ☐ Rheumatoid Arthritis
- ☐ Tendonitis
- ☐ Whiplash
- ☐ Other_____

Nervous System
- ☐ Alzheimer's
- ☐ Herpes Zoster/Shingles
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Spinal Cord Injury
- ☐ Numbness
- ☐ Other_____

Circulatory System
- ☐ Atherosclerosis
- ☐ Deep Vein Thrombosis
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other_____

Digestive System
- ☐ Crohns
- ☐ IBS
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Other _____

Lymph/Immune System
- ☐ Allergic Reactions
- ☐ Chronic Fatigue
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Lymphodema
- ☐ Other_____

Respiratory System
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sinusitis
- ☐ Other_____

Integumentary System (Skin)
- ☐ Athlete's Foot
- ☐ Boils
- ☐ Burns
- ☐ Cold Sore/Herpes
- ☐ Dermatitis
- ☐ Impetigo
- ☐ Open Sore/Wounds
- ☐ Psoriasis
- ☐ Rashes
- ☐ Warts
- ☐ Other_____

Miscellaneous Conditions
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness
- ☐ Pregnant due date:_____
- ☐ Other: _____

6. Please list any accidents or operations you have had and dates: _____
_____

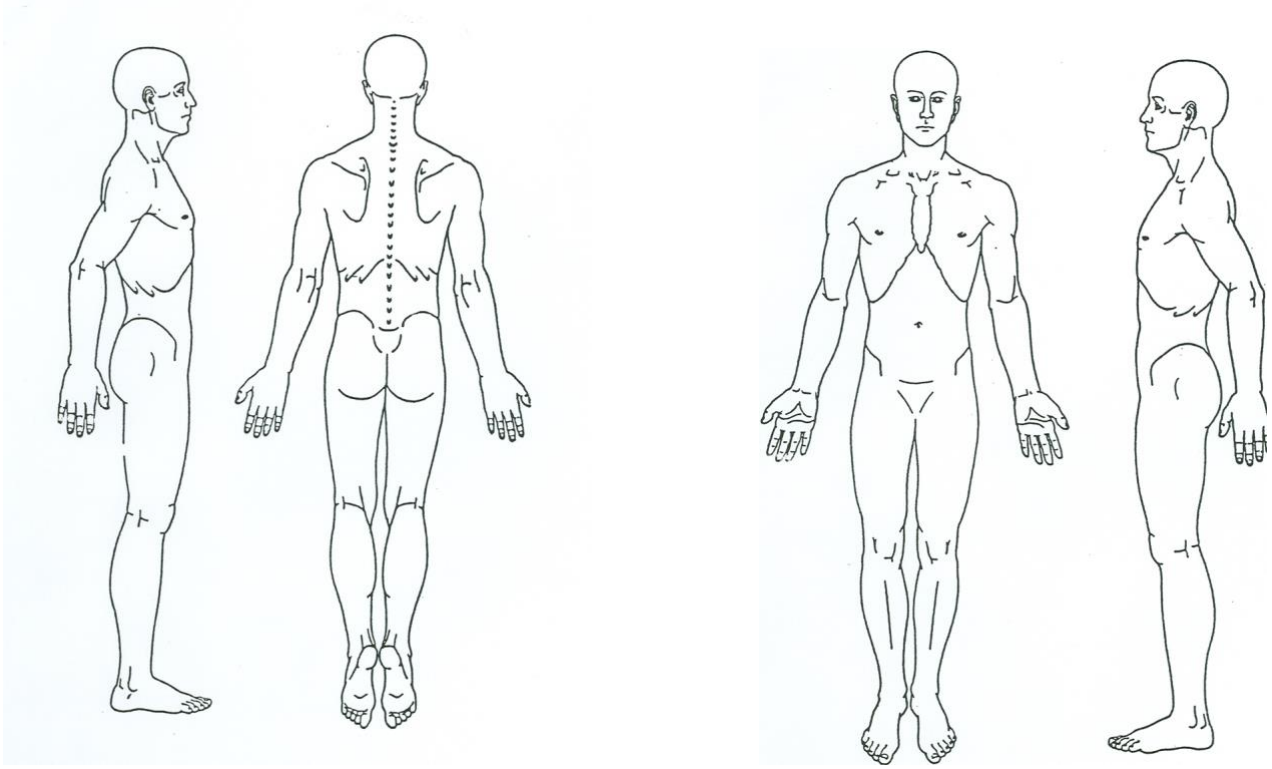
7. Please list any Sports/Regular Physical Activities **you do:**

Cards	Running	Tennis	Quilting
Gardening	Volleyball	Walking	Swimming
Golf	Bowling	Lift Weights	Other: _____

8. Please circle the level of physical activity you do:

None Light Moderate Heavy

9. Please mark on the body forms with an **"X"** where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins/needles, etc.):



_____ (initials) I understand the craniosacral therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand a craniosacral therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand craniosacral therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the craniosacral therapist of any existing medical conditions I may have, and keep the craniosacral therapist informed of any changes in my health and medications in the future. I understand I have the right to refuse craniosacral therapy treatment at any time during the session. I authorize the performance of craniosacral therapy techniques.

I understand that I may be refused treatment if I appear intoxicated or under the influence of drugs.

Signature_____ **Date**_____