Client History Questionnaire

Date: _______________

First Name:_____________________________ Last Name:________________________________

Street Address: ____
City:____
Province:________________________ Country:___________ Postal Code/Zip:________________

Email Address: ____
Phone:______________________Work:_______________________ Cell:_____________________

Age:____________ Gender:_________________ Occupation:______________________________
Referred by:_______________________________

Previous Bodywork Experience:____
____

Fitness Program/Regime:____
____

Primary Concerns:____
____

Minor Concerns:____
____

Symptoms: ____
____

Cause of Symptoms (If Known): ____
____

Initial Date of Symptoms: _________________ What Aggravates Symptons? _______________
____

Pain Pattern: ☐ Constant ☐ On / Off
Other (Any Other Pain Information): ____
____

Stress Level:____

Numbness/Tingling/Weakness in Extremities? ____
____

Injuries: ____
____

Surgeries: ____
____

Scars:____

Past/Present Illness: ____
____

Physicians Seen and Dates Re: These Illnesses/Injuries/Surgeries: ____________________
____

Tests Taken/Dates/Results (MRI/X-RAY/Other): ______________________________
____

Diagnosis: ____
Medication: ____

Have You Ever Experienced the Following? (Check Any that Apply)

- ☐ Acute Stroke
- ☐ Herniated Medulla Oblongata
- ☐ Spina Bifida
- ☐ Whiplash
- ☐ Breast Implants
- ☐ Scars
- ☐ Respiratory Problems
- ☐ Own Birth Trauma
- ☐ Irritable Bowel Syndrome
- ☐ Cerebral Aneurysm
- ☐ Recent Skull Fracture
- ☐ Arnold Chiari Malformation
- ☐ Headaches
- ☐ Broken Bones
- ☐ Grinding Teeth
- ☐ Digestive Issues
- ☐ Tinnitus
- ☐ Acid Reflux
- ☐ Hemorrhage
- ☐ Cerebrospinal fluid leak
- ☐ Increased Intracranial Pressure
- ☐ Vision Problems
- ☐ Dislocations
- ☐ Dental Issues
- ☐ Trauma Giving Birth
- ☐ Sinus Problems

Are You Currently Pregnant? ☐ Yes ☐ No

Any Additional Thoughts or Concerns? ______________________________
____
____

☐ Yes, I have listed all my known medical conditions and physical limitations, and I will inform my therapist of any changes in my health. I understand that a Craniosacral Therapist does not diagnose illness, disease or any other medical, physical or mental disorder.

☐ I have read and understand the “Book Your Appointment” page.

Signature:______________________________ Date: ____________________