Nourishing Life

CRANIOSACRAL THERAPY AND BODYWORK

Health Intake Form

Carla L. Battles, LMP, VCSW

Name: _____ Today's Date: ___/___/_____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ / _____ / _____

Cell Phone: _____ Email: _____

Emergency Contact & Phone Number: _____

How did you find me? Referred by Friend: _____ Internet search: _____

MindBody Search: _____ Other: _____

Your main intention for coming in today: _____

List current medications, pain relievers, or herbs: _____

CHECK ALL BOXES BELOW THAT APPLY FOR PAST OR PRESENT:

past/present

- ○○ Headaches _____
- ○○ Fever _____
- ○○ Sinus problems _____
- ○○ Injuries _____
- ○○ Cancer-benign/malignant _____
- ○○ Car accidents _____
- ○○ Diabetes _____

past/present

- ○○ Sleep disturbances _____
- ○○ infections _____
- ○○ Surgeries _____
- ○○ Major illnesses _____
- ○○ Skin problems _____
- ○○ Digestive problems _____
- ○○ Hypo/hyperthyroid _____

Muscles and Joints

- ○○ Arthritis _____
- ○○ Spinal problems _____
- ○○ Spasms/cramps _____

- ○○ Broken bones _____
- ○○ TMJD/Jaw Pain _____
- ○○ Sprains/strains _____

past/present

past/present

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Muscles and Joints (*continued*)

past/present

past/present

- ○○ Tendonitis _____
- ○○ Weak/sore muscles _____
- ○○ Head injury _____
- ○○ Nerve pain (sciatica, carpal tunnel, tennis elbow,etc) _____
- ○○ Depression/anxiety _____
- ○○ Stiff painful joints _____
- ○○ Fracture to skull or pelvis _____
- ○○ Dizziness/ringing in ears _____
- ○○ Other: _____

Respiratory and Cardiovascular

- ○○ Heart disease _____
- ○○ Stroke/aneurysm _____
- ○○ Swollen ankles _____
- ○○ Asthma, bronchitis _____
- ○○ High/low blood pressure _____
- ○○ Irregular heart beat _____
- ○○ Chest pain-short breath _____
- ○○ Allergies _____

Urinary and Reproductive

- ○○ Bladder/kidney/prostate infections _____
- ○○ Abdominal pain _____
- ○○ Pregnancy _____
- ○○ Painful, emotional menses _____
- ○○ Other: _____

Habits

- ○○ Tobacco/cigar _____
- ○○ Drugs _____
- ○○ Coffee, soda, chocolate _____
- ○○ Alcohol _____

past/present

past/present

Any other health Information or comments you'd like me to know?

_____

_____

_____

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Consent for Care and Agreement

I have reported all health conditions I am aware of and will continue to inform my practitioner if there are changes-so to create safe and informed sessions. I understand Massage and Craniosacral Therapy are not substitutes for medical services-but complements to them. I choose to receive craniosacral or massage therapy. I acknowledge I was provided with the Notice of Privacy Practices and cancellation Policy.

Signature _____ Date ___/___/____