

Client History Form
PLEASE PRINT CLEARLY - THANK YOU

Name _____ Date _____

Address _____ City _____ Zip _____

Phone Home (_____) _____ Work (_____) _____ Cell _____

Gender _____ Age _____ Date of Birth _____ Height _____ Weight _____

Occupation _____ How did you hear about us/Referred by _____

Email _____ Emergency contact _____ Phone _____

Doctor _____ Chiropractor _____

Please complete the following questions as well as you can. This information will help us provide you with the most effective and safest treatment session.

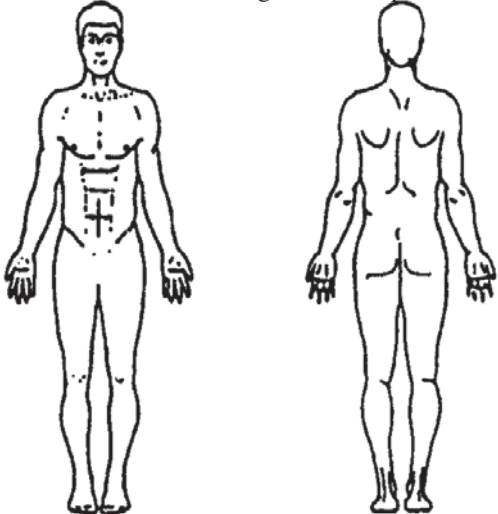
Reason you are coming to see us: _____

Primary physical complaint: _____

How long have these been occurring? _____

Please indicate on this scale your level of pain: No pain Extreme pain
|-----|
Please indicate on this scale your ability to function: No limit Extreme difficulty
For example: Range of motion, daily activities, etc. |-----|

Please indicate on this diagram where pain or discomfort is occurring. Any additional comments:



What therapies have you used for this situation? _____

What therapies have been helpful? _____

Are you working with any other health care practitioner at time time? If yes, what for?

Medications you are presently taking and why: _____

Please list any previous surgeries, injuries, accidents: _____

What type of exercise do you do? _____ How many times per week? _____

Please state what you feel are priorities (ex. health concerns, family, job, activities of interest, etc.)

1. _____ 2. _____ 3. _____

Please state what your goals are for: Week 1: _____

Month 1: _____ Month 3: _____

Do any of the following apply to you?

Y / N Contact lenses	Y / N Dentures	Y / N Emotional abuse	<u>For women only:</u>
Y / N History of psychosis	Y / N Suicidal tendencies	Y / N Abuse of alcohol/drugs	Are you pregnant? Y / N
Y / N Physical/sexual abuse	Y / N Working with a mental health care professional		Are you trying to get pregnant? Y / N

Please check any of the following conditions that apply to you:

<input type="checkbox"/> AID/HIV	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Anemia/Blood disorders	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Infection Staph or other	<input type="checkbox"/> Skin disorder or infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Injuries to back, neck or spine	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Sudden weight loss or gain
<input type="checkbox"/> Edema/lymphedema	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Recent acute injuries	<input type="checkbox"/> Varicose veins, blood clots or tumors
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Osteo-arthritis: location _____	
<input type="checkbox"/> Headaches: How often? Location? And when? _____		
<input type="checkbox"/> Chemotherapy, radiation, removal of lymph nodes? Where: _____		

CranioSacral Path can provide relief from a variety of conditions including nutritional, emotional and physical stresses. Please check off any of the following items that you would like help with or would like more information about:

<input type="checkbox"/> Helping my body to relax and release tension and stress	<input type="checkbox"/> Emotional stresses or trauma
<input type="checkbox"/> Healing from an injury or surgery	<input type="checkbox"/> Feet problems, plantar fasciitis & bunions
<input type="checkbox"/> Depression, anxiety or self-esteem issues	<input type="checkbox"/> Dyslexia, time problems, balance
<input type="checkbox"/> Pain of unknown origin or pain that won't seem to get better	<input type="checkbox"/> Posture or flexibility
<input type="checkbox"/> Birth via c-section, breech, forceps or other trauma	<input type="checkbox"/> Migraines or headaches
<input type="checkbox"/> Problems with discs or vertebra of the the spine, bulging discs or scoliosis	
<input type="checkbox"/> Temporal mandibular joint (TMJ) dysfunction, pain, grinding, popping or clenching	
<input type="checkbox"/> Nerve related problems: tinnitus, tingling of nerves, difficulty with senses of hearing, taste, sight	
<input type="checkbox"/> Other, please specify: _____	

I would like more information about:

<input type="checkbox"/> Bach Flower Essences	<input type="checkbox"/> CranioSacral Therapy (CST)	<input type="checkbox"/> CST for Pediatrics
<input type="checkbox"/> Enzyme Nutrition	<input type="checkbox"/> Lymph Drainage	<input type="checkbox"/> SomatoEmotional Release

If there was one thing that we could help you achieve, what would it be? _____

Anything else of importance to you that you would like to share with us? _____

The information that I have provided regarding my health history indicates all conditions including but not limited to medical, physical and mental health conditions known to me at this time. I shall advise Julie McKay, WCB, CST-D, BFRP in writing of any and all changes in my health. By signing below I give permission to Julie McKay to contact me from time to time by mail, phone or email. I authorize Julie McKay to contact and share my health information with any health professional that I indicate I am working with.

Cancellation policy: There will be no charge for missed appointments provided that **24 hours notice** has been given, otherwise the full cost will be charged to me for all missed appointments.

Signature _____ Date: _____