A BALANCED BODY | Rose Stoudt Manual Therapies | 406 880-8060

MEDICAL CASE HISTORY

Name: ______________________________________ **Date of Birth**______________ **Age:** ______

Address: ____________________________________ **Cell Phone:** ________________________

City/State/Zip: ________________________________ **Home Phone:** ________________________

Occupation: __________________________________ **Work Phone:** ________________________

Referred by: __________________________________ **E-mail Address:** _____________________

Partner/Spouse Name: __________________________

In Case of Emergency, contact: ___________________ **Cell Phone:** ________________________

Home Phone: _________________________________ **Work Phone:** ________________________

PLEASE MARK (X) IF YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING:

_____ **Headaches**
_____ **Head Injury**
_____ **Jaw or TMJ**
_____ **Neck**
_____ **Neck Injury**
_____ **Shoulder(s)**
_____ **Upper Back**
_____ **Mid-Back**
_____ **Lower Back**
_____ **Back Injury**
_____ **Scoliosis**
_____ **Disc problems**
_____ **Dislocations**
_____ **Skin problems**

_____ **Arms/Hands/ Fingers/Elbow**
_____ **Hip**
_____ **Sciatica Pain**
_____ **Leg**
_____ **Knee**
_____ **Ankle**
_____ **Foot**
_____ **Joint problems**
_____ **Joint injury**
_____ **Fractures**
_____ **Pulled Muscles**
_____ **Muscle Cramping**
_____ **High Blood Pressure**

_____ **Allergies**
_____ **Arthritis**
_____ **Breast**
_____ **Bruises, Cuts or Abrasions**
_____ **Chest Pain**
_____ **Circulation**
_____ **Diabetes**
_____ **Dizziness/**
_____ **Ear problems**
_____ **Epilepsy**
_____ **Eye problems**
_____ **Heart**

_____ **Inflammation**
_____ **Kidney**
_____ **Liver-Gallbladder**
_____ **Low Blood Pressure**
_____ **Reproductive Organs (Such as --** ***cramps, infertility impotency)***
_____ **Respiratory**
_____ **Sinus problems**
_____ **Thyroid Disorder**
_____ **Urinary problems**
_____ **Varicose Veins**

PLEASE ANSWER THE FOLLOWING QUESTIONS AND DESCRIBE BRIEFLY: **Male ___ Female___**

Have you ever had Cranial Sacral Therapy before? Yes No
(*If female*) Are you pregnant? Yes No
(If female) Are you attempting to get pregnant? Yes No
Are you presently under the care of a medical professional? Yes No
Please specify who and for what: ____
Are you on any medications? Please specify: ____________________________________
____
Do you have numbness, tingling or other nerve problems? Please specify: ______________
____
Do you have range of motion problems anywhere? Please specify: ____________________
____
Do you have any MAJOR DISEASE (S) or ILLNESS? Please specify: ___________________
____
Do you wear (please check) ____ Orthotics ____ Heel Lifts ____Arch Supports ____ Inner soles

I have read and completed all the above questions to the best of my knowledge. I take full responsibility to notify Rose Stoudt of any changes in my health status or the above information.

Signature ____ ***Date*** ______________________

Parent/Guardian ___________________________________ ***Date*** ______________________
(If a minor)