

CONFIDENTIAL CASE INFORMATION

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:

- | | | | |
|----------------------------------------|-------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arms/Hands/
Fingers/Elbow | <input type="checkbox"/> Allergies | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Hip | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Jaw or TMJ | <input type="checkbox"/> Sciatica Pain | <input type="checkbox"/> Breast | <input type="checkbox"/> Liver-Gallbladder |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Leg | <input type="checkbox"/> Bruises, Cuts
or Abrasions | <input type="checkbox"/> Low Blood
Pressure |
| <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Knee | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Reproductive
Organs (Such as --
<i>cramps, infertility</i>
<i>impotency</i>) |
| <input type="checkbox"/> Shoulder(s) | <input type="checkbox"/> Ankle | <input type="checkbox"/> Circulation | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Foot | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Mid-Back | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Dizziness/
Ear problems | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Lower Back | <input type="checkbox"/> Joint injury | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Fractures | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Pulled Muscles | <input type="checkbox"/> Heart | |
| <input type="checkbox"/> Disc problems | <input type="checkbox"/> Muscle Cramping | | |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Skin problems | | | |

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)