LAURA INMAN MITCHELL
CranioSacral Therapist

NEW CLIENT INFORMATION

Name ____Date________________________

Address ____

City _________________________ State _____ Zip ___________

Occupation ______________________________________ Birth Date_____________________

Email Address ____

May I add you to my mailing list? ____

Telephone # _________________Cell # ___________________ Work ___________________

Emergency Contact – Name__________________________________
Phone#_____________________

How did you learn about me? ____________________________

Have you received Professional Massage Therapy or Bodywork before? _________

What Kinds? _________________________________ How often? _________________________

Please check off any of the following conditions or symptoms which apply to you now or in the past:

____ High Blood Pressure
____ Contact Lens
____ Low Back Pain
____ Allergy to Nut Oils
____ Osteoporosis
____ Diabetes
____ Pregnant
____ Blood Clots
____ Low Blood Pressure
____ Varicose Veins
____ Bursitis
____ Skin Infections
____ Hypo or Hyperglycemia
____ Contagious Conditions
____ Muscle Sprain / Strain
____ Heart Attack / Stroke
____ Arthritis
____ Headaches or Migraines
____ TMJ Disorder
____ Head injury
____ Pelvic injury
____ Hearing difficulties
____ Seizures
____ Depression
____ Other Conditions

Please list and explain other conditions/symptoms you are or have experienced: ______________

Have you had any serious or chronic illness, operations, or traumatic accidents? _______

If yes, please give dates and details:____

____

OVER PLEASE

Are you currently, or have you at any time within the last 12 months been under the care of a physician? If so, for what condition?

Are you on any medication? _______
If yes, which ones and for what condition?____

If appropriate, and with your knowledge, may I have permission to contact your Doctor / Therapist? _____

Doctor / Therapist Name: ____________________________Telephone __________________

Lifestyle choices
What forms of exercise to you enjoy regularly and how often ?
____

Do you drink caffeinated beverages? _______

Do you smoke cigarettes? _________

Do you consume alcohol? _________

I have completed this health form to the best of my knowledge. I understand that CranioSacral Therapy services are a therapeutic health aid. They do not take the place of a physician's care when indicated. Any information exchanged during a session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24 notice, I agree pay any missed appointment charge applicable.

Signature ____ Date _____________________

If a minor, signature of Parent/Guardian is required:

Signature ____ Date _____________________