IAM Craniosacraal Therapie

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GENERAL INFORMATION

Name: _____

Address: _____

Postal code: _____ City: _____

Telephone: _____

Cell phone: _____

Email: _____

Date of Birth: _____ Gender: ☐**F** ☐**M**

Contact person in case of emergency: _____ Telephone: _____

CURRENT HEALTH

Current symptoms: _____

When did this start? _____ Did you see a doctor? ☐**Yes** ☐**No**

What was the diagnosis/treatment? _____

Did symptoms get: ☐ Worse ☐ Same ☐ Varies ☐ Better

Pain level (10 being the worse): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe your pain when it is at its worse _____

_____

Current medication: _____

_____

BACKGROUND/HISTORY

1) Name of family physician? _____ Telephone: _____

2) Did you get referred to Craniosacral Therapy by him/her? ☐**Yes** ☐**No**

3) Have you had surgery in the past? ☐**Yes** ☐**No**

If so, please describe _____

_____ Year of surgery(ies): _____

4) Did you ever suffer from brain injury (light/severe)? (ie. during sports or accident) ☐**Yes** ☐**No**

If yes, describe brain injury: _____

Date(s) of brain injury: _____

5) Did you suffer a stroke or a TIA in the last 6 months? ☐**Yes** ☐**No**

Are you at risk for a stroke or TIA? ☐**Yes** ☐**No**

6) Did you have a heart attack during the past 6 months? ☐**Yes** ☐**No**

Are you at risk for a heart attack or heart failure? ☐**Yes** ☐**No**

7) Have you ever been diagnosed with cancer? ☐**Yes** ☐**No**

Type: _____

This page describes a list of conditions and symptoms, which could apply to you. Please be as detailed as possible to give me a more accurate insight into your general state of health which will allow me to provide you with the best care.

Tick all the boxes that apply to you:

GENERAL	**Now**	**Past**
Fatigue	☐	☐
Dizziness	☐	☐
Confusion	☐	☐
Fainting	☐	☐
Burn-out/Depression	☐	☐
Anxiety	☐	☐
Sleeplessness/insomnia	☐	☐
Hearing loss	☐	☐
Tinnitus	☐	☐
Bad eyesight/blindness	☐	☐
Sinus problems	☐	☐
Facial pain	☐	☐
Jaw and mouth problems	☐	☐

HEART & ARTERIES	**Now**	**Past**
High blood pressure	☐	☐
Low blood pressure	☐	☐
Heart condition	☐	☐
Chronic congestive heart failure	☐	☐
Heart attack	☐	☐
Pacemaker/other devise	☐	☐
Stroke	☐	☐
Cold hands and/or feet	☐	☐

BREATHING	**Now**	**Past**
Chronic cough	☐	☐
Shortness of breath	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
COPD/Emphysema	☐	☐

VIRUS/INFECTION	**Now**	**Past**
Skin condition(s)	☐	☐
Herpes	☐	☐
HIV	☐	☐
Hepatitis	☐	☐

MUSCLE/SKELETON	**Now**	**Past**
Muscle stiffness	☐	☐
Bursitis (shoulder/hip/elbow/knee)	☐	☐
Frozen shoulder	☐	☐
Chronic backpain	☐	☐
Neck pain	☐	☐
Temporomandibular disorder or TMD	☐	☐
Difficulty chewing/clicking jaw	☐	☐
Whiplash	☐	☐
Headache	☐	☐
Migraines	☐	☐
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Scoliosis	☐	☐

DIGESTION	**Now**	**Past**
Difficulty swallowing	☐	☐
Nausea/Vomiting	☐	☐
Celiac Disease	☐	☐
IBD/Inflammatory bowel disease	☐	☐
Ulcerative Colitis	☐	☐
Crohn's Disease	☐	☐
Bladder / urinary tract issues	☐	☐
Liver Disease	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐

☐ Other conditions or symptoms that are not listed, but might be important:

_____

Date: _____

Name: _____ **Signature:** _____