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:	
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): \Box 1 \Box 2 \Box 3 \Box	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/h	er? □ Yes □ N o
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.	
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
Туре:	

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:

<u>GENERAL</u>	Now	Past	VIRUS/INFECTION	Now	Past
Fatigue			Skin condition(s)		
Dizziness			Herpes		
Confusion			HIV		
Fainting			Hepatitis		
Burn-out/Depression					
Anxiety			MUSCLE/SKELETON	Now	Past
Sleeplessness/insomnia			Muscle stiffness		
Hearing loss			Bursitis (shoulder/hip/elbow/knee)		
Tinnitus			Frozen shoulder		
Bad eyesight/blindness			Chronic backpain		
Sinus problems			Neck pain		
Facial pain			Temporomandibular disorder or T		
Jaw and mouth problems \qed			Difficulty chewing/clicking jaw		
			Whiplash		
HEART & ARTERIES	Now	Past	Headache		
High blood pressure			Migraines		
Low blood pressure			Rheumatoid arthritis		
Heart condition			Osteoarthritis		
Chronic congestive heart failure			Scoliosis		
Heart attack			DIGESTION		
Pacemaker/other devise			DIGESTION	Now	Past
Stroke			Difficulty swallowing		
Cold hands and/or feet \Box			Nausea/Vomiting		
			Celiac Disease		
BREATHING	Now	Past	IBD/Inflammatory bowel disease		
Chronic cough			Ulcerative Colitis		
Shortness of breath			Crohn's Disease		
			Dladdon / uninom, tract iccues		
Bronchitis			Bladder / urinary tract issues		_
Asthma			Liver Disease		
	_		Liver Disease Kidney Disease		
Asthma			Liver Disease		
Asthma			Liver Disease Kidney Disease Diabetes		
Asthma COPD/Emphysema			Liver Disease Kidney Disease Diabetes		
Asthma COPD/Emphysema			Liver Disease Kidney Disease Diabetes		