

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:

<u>GENERAL</u>	Now	Past	<u>VIRUS/INFECTION</u>	Now	Past
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Burn-out/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<u>MUSCLE/SKELETON</u>	Now	Past
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Sleeplessness/insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis (shoulder/hip/elbow/knee)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Frozen shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	Chronic backpain	<input type="checkbox"/>	<input type="checkbox"/>
Bad eyesight/blindness	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Temporomandibular disorder or TMD	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty chewing/clicking jaw	<input type="checkbox"/>	<input type="checkbox"/>
Jaw and mouth problems	<input type="checkbox"/>	<input type="checkbox"/>	Whiplash	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEART & ARTERIES</u>	Now	Past	Headache	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<u>DIGESTION</u>	Now	Past
Pacemaker/other devise	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands and/or feet	<input type="checkbox"/>	<input type="checkbox"/>	Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
<u>BREATHING</u>	Now	Past	IBD/Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Bladder / urinary tract issues	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

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

Date: _____

Name: _____

Signature: _____