Biodynamic Craniosacral Therapy

True Touch Therapy
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Client History and Information

Name: _____ **Birth Date:** _____

Address: _____ **Best Contact #:**_____

City: _____

Emergency Contact Name :_____ **Relationship:**_____

Their Phone Number: _____

Your Relationship Status: _____

How did you hear about me?_____

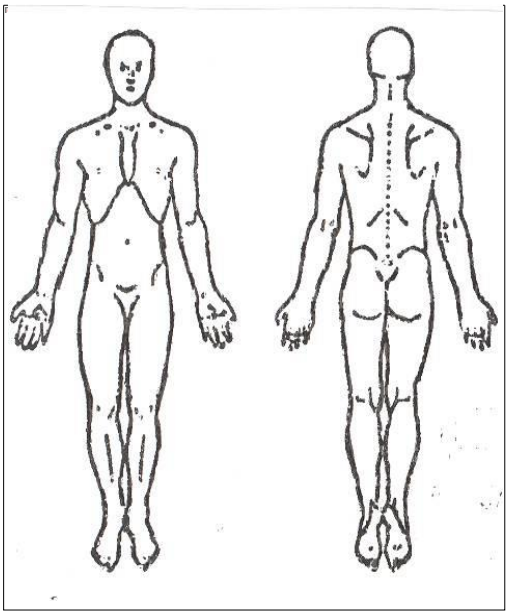
Occupation: _____ **Employer:** _____

Sports/hobbies: _____

How is your general health? _____

What are your intentions for this treatment? _____

Note the areas of discomfort, injury or pain on the figures



Present Symptoms: What is the major condition you want to improve? _____

_____

What caused it? _____

What relieves it? _____

What other therapies have been helpful? _____

_____

List any medications and nutritional supplements you are taking: _____

_____

Medical / Surgical History_____

_____

_____

Accident History _____

Are you having any problems with the following: **√ for new problem** **× for old problem**

___allergies
___ arthritis
___asthma
___anxiety
___back pain
___bladder
___bowels
___cancer
___carpal tunnel
___chronic fatigue
___depression
___diabetes
___disc issues
___digestion/stomach
___dizzy/fainting
___energy levels
___eyes
___fatigue
___female problems
___fibromyalgia
___gallbladder
___headache
___heart trouble
___hearing loss
___hiatus hernia
___high/low blood pressure
___hips
___hormonal issues
___inflammation
___jaw pain (TMJ)
___ joints
___kidney issues
___legs/feet
___liver
___lungs/chest
___male problems
___ migraine
___mouth/teeth
___neck pain
___ribs
___ringing in ears
___scoliosis
___sciatica
___seizures
___stress: moderate/high
___skin
___sleep issues
___shoulder pain
___skin disorders
___sinus
___sprains/strains
___stroke
___ swollen feet or legs
___tendonitis
___tingling/numbness
___varicose veins
___whiplash

Dental history – braces, extractions, grinding, etc _____

Describe your birth:

Additional information:

Informed Consent

I, _____, (client) understand that the bodywork therapies as practiced by Tracey Pike are intended to reduce pain, integrate structural imbalances, decrease myofascial restrictions, decrease neural impingement, increase range of motion, improve circulation, enhance relaxation, increase the experience of overall health and offer a positive experience of touch.

I understand that the therapies are not a substitute for medical treatment or medications and that it is recommended that I work concurrently with my Primary Caregiver for any condition I may have. I am aware that the therapist does not diagnose illness or disease and does not prescribe medications nor perform spinal manipulations.

I have informed the therapist of all my known physical conditions, medical conditions and medications, and I will keep the therapist updated on any changes.

Signature:_____ Date:_____