Integrated Body Arts Health Information

Full Name:________________________________________________Date:_____________________

Address:____________________________City:______________State:_________Zip:______________

Email address: ____________________________Cell phone: _________________Other: _______________

Emergency Contact:_________________________________Phone:_________________________________________

Birth Date:_______________Occupation:________________Referred by:_____________________________

Have you previously experienced Craniosacral Therapy? Yes _____ No______

Are you currently under a physician's care for any conditions? Yes _____ No______
If yes, please explain: ____________________________________________________________

Are you currently receiving other complementary care such as Acupuncture, Homeopathic, Nutritional, Naturopathic, herbal, other? (please circle) Yes _____ No ______

What do you do to manage stress in your life? _________________________________________________

__________________________________________________________________________

Past Surgeries: __________________________________________________________________

__________________________________________________________________________

Injuries/Traumas: ________________________________________________________________

__________________________________________________________________________

Current Medications: _____________________________________________________________

__________________________________________________________________________

Allergies: _______________________________________________________________________

**PLEASE TURN PAGE OVER**

Circle all of the conditions or symptoms you currently have, or have had in the past

| | | | |
|---|---|---|---|
| Anemia | Cancer | Head injury | Migraine/headaches |
| Anxiety | Chemical dependency | Heart Disease | Osteoporosis |
| Arthritis | Concussion | Hepatitis | Stroke |
| Asthma | Depression | Herniated Disc | TMJD |
| Blood clots | Edema/swelling | High blood pressure | Thyroid dysfunction |
| Bursitis | Eating Disorder | HIV/AIDS-infectious disease | Tumor |
| Bronchitis | Fatigue, low energy | Insomnia/trouble sleeping | Ulcers |
| | Lymphedema | Varicose Veins | Whiplash |

Signature: ___________________________________________ Date:_______________