Integrated Physical Therapy and Counseling

MASSAGE THERAPY / CRANIOSACRAL THERAPY INFORMATION

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home) _____ (wk) _____ (cell) _____

Occupation: _____ email: _____

Briefly explain your experience with massage therapy/craniosacral therapy (frequency, likes, dislikes), physical therapy and/or chiropractic care.

Please explain your present state of health. Do you have any illness, recently or presently? Do you have any systemic pathologies (rheumatoid arthritis, FMS, cancer)? Are you pregnant? What is your general activity level (regular exercise)?

What is your purpose of receiving massage/cst (general relaxation, specific area work)?

This massage/CST is ultimately for you. If there is anything that makes you uncomfortable (temperature of the room, music, pressure of touch), please let us know. Additionally, all clientele will be draped during the massage to ensure the client's security and safety.

Your fee for this session is $ _____, payable in cash, check, or credit card.

CANCELLATION POLICY: This office requires 24-hour notice on all appointments. A charge will be imposed on all appointments not cancelled with at least 24 hours or on any missed appointments. The payment for this charge is expected before your next scheduled visit.

Signature: _____ Date: _____

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Patient Health History

Name: _____ Date: _____

Date of Birth: _____ Date of Last Physical: _____

Present Complaint of Illness: _____

_____

_____

Is this a recurring problem? _____

Any recent surgery related to this condition? If yes, please give date and type of surgery.

_____

Are you currently experiencing any of the following symptoms?

	YES	NO
Headaches	☐	☐
Vertigo	☐	☐
Difficulty swallowing	☐	☐
Visual Disturbances	☐	☐
Nausea/ Vomiting	☐	☐
Breathing difficulty	☐	☐
Chest Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in urine or stool	☐	☐
Neck pain	☐	☐
Abdominal Pain	☐	☐
Low back pain	☐	☐
Balance difficulty	☐	☐
Weakness	☐	☐
Loss of sensation	☐	☐

Do you have, or have had in the past, any of the following conditions:

	YES	NO
High Blood Pressure	☐	☐
Cardiac Problems	☐	☐
Seizures	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Thyroid Conditions	☐	☐
Joint Replacements	☐	☐

If you have answered "yes" to any of the above conditions, please explain.

_____

_____

_____

_____

Please list the medications you are taking. _____

_____

_____

Please list your recreational activities. _____

_____

Please write down one goal you would like to accomplish in physical therapy.

_____

_____ _____

Signature Date