



# The Cranial Therapy Centre

## Client Health History

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Parent/Guardian name (if applicable)

Address: \_\_\_\_\_

Tel: Home \_\_\_\_\_

Business \_\_\_\_\_

Cell \_\_\_\_\_

Email: \_\_\_\_\_

Birth date: \_\_\_\_\_

Did a health care practitioner refer you?

Yes  No

If yes, please provide their name and address:

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

What is the reason you are seeking treatment? Please include the location of any tissue or joint discomfort.

\_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

Overall, how is your general health? \_\_\_\_\_

Are you currently receiving treatment from another health care professional?  Yes  No

If yes, for what? \_\_\_\_\_

Current

Medications and/or remedies: \_\_\_\_\_

Conditions being treated: \_\_\_\_\_

What other treatments have you received? \_\_\_\_\_

Have you ever received massage therapy before?

Yes  No

Past

Injuries (nature and dates): \_\_\_\_\_

Surgery (nature and dates): \_\_\_\_\_

PLEASE COMPLETE THE FORM ON THE OTHER SIDE

**PLEASE CANCEL AT LEAST 24 HOURS IN ADVANCE TO AVOID BEING CHARGED FOR MISSED APPOINTMENTS**

### OFFICE USE ONLY

Annual update \_\_\_\_\_

verbal consent recieved \_\_\_\_\_

## Client Health History continued

Please indicate conditions presently causing problems, as well as conditions which were a problem in the past.

### BABIES & CHILDREN Present    Past

- Birth trauma .....  .....
- Feeding problems .....  .....
- Colic .....  .....
- Restlessness/sleep problems .....  .....
- Recurrent ear infections .....  .....
- Developmental Delays .....  .....
- Behavioural issues .....  .....
- Hyperactivity/ADD/ADHD .....  .....
- Learning Disabilities .....  .....
- Eye motor problems .....  .....
- PDD/autism .....  .....

### RESPIRATORY Present    Past

- Chronic cough .....  .....
- Shortness of breath .....  .....
- Bronchitis .....  .....
- Asthma .....  .....
- Emphysema .....  .....

### CARDIOVASCULAR Present    Past

- High blood pressure .....  .....
- Low blood pressure .....  .....
- Chronic congestive heart failure .....  .....
- Heart attack .....  .....
- Heart disease .....  .....
- Phlebitis/varicose veins .....  .....
- Stroke/CVA .....  .....
- Cardiovascular aneurysm .....  .....
- Pacemaker/other device .....  .....
- Coldness in extremities .....  .....

### DIGESTIVE CONDITIONS Present    Past

Please describe: .....  .....

\_\_\_\_\_

### INFECTIONS Present    Past

- Skin conditions/infections .....  .....
- Herpes .....  .....
- HIV .....  .....
- TB .....  .....
- Hepatitis .....  .....

### WOMEN Present    Past

- Gynecological conditions .....  .....
- Pregnant, due .....  .....

### HEAD/NECK Present    Past

- Headaches .....  .....
- Migraines .....  .....
- Jaw problems (pain/clicking/locking) .....  .....
- Whiplash .....  .....
- Vision problems or loss .....  .....
- Ear problems or hearing loss .....  .....
- Ringing in the ears .....  .....
- Fainting .....  .....
- Dizziness .....  .....
- Sinus problems .....  .....
- Facial pain .....  .....
- Closed head injury .....  .....
- Other neurological conditions .....  .....

### OTHER CONDITIONS Present    Past

- Epilepsy/seizures .....  .....
- Diabetes .....  .....
- Cancer: where .....  .....
- Arthritis: family history .....  .....
- Susceptible to colds/infections .....  .....
- High stress levels .....  .....
- Insomnia .....  .....
- Fatigue .....  .....
- Nervousness .....  .....
- Numbness/tingling/loss of sensation .....  .....

### EVERYONE

Is there any other information your therapist should know?

\_\_\_\_\_

\_\_\_\_\_

Presence of internal pins, artificial joints, or special equipment \_\_\_\_\_

\_\_\_\_\_

Known allergies or hypersensitive reactions?

\_\_\_\_\_

Other diagnosed diseases or medical conditions?

\_\_\_\_\_

Receive occasional e-updates on news, events and workshops happening at the Cranial Therapy Centre?    Yes     No

Therapist Use Only \_\_\_\_\_

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