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 ______________________

Occupation: ______________________

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.

____

____

____

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 received ______________________

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:	❑	❍

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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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