New Bern Intuitive Wellness

CranioSacral Therapy Intake

Name ____

Address ____________________________________ City _____________ State _____ ZIP _________

Home # (_____) ________ Cell # (_____) ________ E-mail address ________________________________

Occupation ________________________________ Referred by _______________________________

Date of Birth _______________________ □ Male □ Female □ Other ______________________________

Primary symptoms (your major complaint) ____

____

When did you first notice these major complaints? ____

Minor complaints (other areas of pain or concern) ____

____

What brought it on? ____

What activities aggravate the condition? ____

Is this condition getting progressively worse? ____

Is this condition interfering with your work? ____________ sleep? _________ daily routine? ____________

What do you believe is wrong with you? ____

What have you done to get relief? ____

Have you been evaluated or diagnosed by a physician? ____

If yes, when? __________________ What was the diagnosis? ____________________________________

Name of physician ____ Phone # (_____)_________

Past History

Have you had similar problems before? □ Yes □ No if yes, please explain _____________________________

What caused the episodes? __________________ What relieved them? __________________________

Did they prevent you from working? □ Yes □ No Hospitalize you? □ Yes □ No Disable you? □ Yes □ No

What was the previous diagnosis? ____

What were the treatments? ____

Did they help? □ Yes □ No

Are you on any medication? □ Yes □ No Please list: ____

____

How many physicians have treated you for this injury/condition? _________________________________

Are you taking any of the following: (Circle all that apply)

Laxatives	Sedatives	Sleeping pills	Aspirins	Pain medication	Anti-inflammatory
Insulin	Herbs	Diet supplements	Vitamins	Anti-depressants	Hormones

Other: ___________________________

Social Habits:

	Heavy	Moderate	Light	None
Alcohol	______	______	______	______
Coffee/Caffeine	______	______	______	______
Tobacco	______	______	______	______
Exercise	______	______	______	______
Weekly sugar intake	______	______	______	______

Have you ever:

	Yes	No	Describe briefly
Had any operations?	_____	_____	____
Broken any bones?	_____	_____	____
Been in an accident?	_____	_____	____
Had whiplash?	_____	_____	____
Arnold-Chiari Malformation	_____	_____	____
Brain Stem Herniation	_____	_____	____
Latex Allergy	_____	_____	____
Cautions concerning changes in intracranial fluid pressure	_____	_____	____

Do you have any difficulty with the following? Please check all that apply

- ☐ Headaches/Migraines
- ☐ Anxiety/nervousness/Inner tension
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Chronic ear infections
- ☐ Inner tension
- ☐ Asthma
- ☐ Tightness of shoulder muscles
- ☐ Loss of taste or smell
- ☐ Neuritis in arms and hands
- ☐ Pins and needles in arms and hands
- ☐ Pins and needles in legs
- ☐ Muscle spasms in neck
- ☐ Head feels too heavy
- ☐ Slipped disc/bulging
- ☐ Pinched nerves
- ☐ Swollen joints
- ☐ Allergies
- ☐ Fatigue
- ☐ Insomnia
- ☐ Dizziness/Vertigo
- ☐ Irritability
- ☐ Arthritis
- ☐ Grating in neck
- ☐ Emotional imbalance
- ☐ Tightness in throat
- ☐ Nervous stomach
- ☐ Stomach trouble
- ☐ Chest pains
- ☐ Swollen ankles
- ☐ Twitching of face
- ☐ Chronic bronchitis
- ☐ Disc herniation
- ☐ Heart pain
- ☐ Fainting
- ☐ PTSD
- ☐ Loss of balance
- ☐ Chronic pneumonia
- ☐ Wearing glasses
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Rheumatic fever
- ☐ Bladder trouble
- ☐ Diabetes
- ☐ Cancer
- ☐ T.B
- ☐ Face flushed
- ☐ Sleeping problems
- ☐ Disc rupture
- ☐ Heart palpitations
- ☐ Liver trouble
- ☐ Seizures
- ☐ Ringing in ears
- ☐ Lights bother eyes
- ☐ Gastric Reflux
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Thyroid trouble
- ☐ Cold hands
- ☐ Ulcers
- ☐ TMJ Dysfunction
- ☐ Shortness of breath
- ☐ Loss of memory
- ☐ Painful joints
- ☐ Cold sweats
- ☐ Nausea
- ☐ Other

Male only:		Female only:	
□ History of prostate trouble	□ Pain in the groin area	□ Easily fatigued	□ I.U.D. Diaphragm
□ Urination difficult or dribbling	□ Sacroiliac or low back pain	□ Premenstrual tension/depression	□ Birth Control Pills
□ Frequent night urination	□ Tire easily	□ Menstruation excessive/prolonged	□ Breast implants
□ Burning upon urination	□ Lack of energy	□ Menstruation scanty/missing	□ Hysterectomy
□ Pain in the shoulders	□ Nervousness	□ Vaginal discharge	# of pregnancies _____
□ Persistent abdominal pain	□ Excessive perspiration	□ Painful breasts	Births _____
□ Pain on the outside of heels and legs	□ Dizziness	□ Menopausal hot flashes, etc	Difficult pregnancies ____
□ Diminished sex drive	□ Burning or pain during orgasm	□ Melancholia of long standing	Difficult births _____

Do you currently have or have you had any recent:

	No	Yes (Please describe)		No	Yes (Please describe)
Physical traumas (falls, blows, accidents)	□	□ _____________________	Change in medication	□	□ ________________________
Surgeries/medical procedures	□	□ _____________________	Injection	□	□ ________________________
Changes in medical routine	□	□ _____________________	Antibiotic use	□	□ ________________________
Do you currently have cancer	□	□ _____________________	Undergoing chemotherapy	□	□ ________________________
Mental/emotional changes	□	□ _____________________	Steroid use	□	□ ________________________
Unexplained weight gain/loss	□	□ _____________________	Fever	□	□ ________________________
Significant change in life circumstance	□	□ _____________________			

Please write the LETTER and draw a line where you are experiencing the following sensations:

A – Achy
T – Tightness
N – Numbness
P – Pins and Needles
B – Burning sensation
S – Stabbing Pain
W – Weak