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: _____

Patient name: _____

Parent/Guardian name: _____
(if applicable)

Address: _____

_____

Tel: Home _____

Business _____

Cell _____

Email: _____

Receive occasional emails? Yes ❑ No ❑

How would you like your appointment reminder? Phone:❑ Email: ❑

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: _____

Overall, how is your general health? _____

_____

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

_____

_____

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:	❑	❍

_____

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?

_____

Therapist Use Only _____

_____

_____

_____

_____