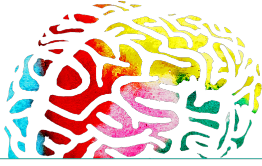

The Beautiful Brain

Craniosacral Client Intake Form

today's date________________

____
Name, first and last.

____
Phone and email

____
Home Address

____
Emergency Contact

____
Date of Birth

Are you experiencing any of the following symptoms? (Please circle)

Headache: front sides back all over

Eye strain or tension

Neck pain

Jaw pain, teeth grinding, dental work.

Nausea

Dizziness

Sinus pressure

Tinnitus/ringing in the ears

Memory difficulty

Anxiety

Depression

High Blood Pressure

Back pain

Pelvic pain

Numbness or tingling in legs

Please share any details on these or any other symptoms you experience.
Was there an accident? Trauma? When did this happen? How long have you had these symptoms?

____

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Have you received treatment for any of your symptoms? Please circle and add the date received.

Physical Therapy

Vestibular Therapy

Occupational Therapy

Ear/Nose/Throat

Neurology

Acupuncture

Massage Therapy

Chiropractic

Craniosacral Therapy

Please share anything else that may be helpful for your session.

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How did you hear about us? ____