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Health History Questionnaire

This information is considered confidential. If you have any questions, please ask. If you have anything you wish to bring to my attention that is not addressed on this form, please note it in the "Comments" section. Thank you for taking the time to fill this out.

Only questions marked with an asterisk * are required.
For all remaining questions, you are welcome to be as thorough... or as brief... as you like.

Date_____

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*Name_____ *Date of Birth_____
*Address _____ Occupation_____
*Phone # _____ *Email address:_____
Main Health Care Provider_____
*Emergency Contact_____*Relationship_____ *Phone_____

Main issue you would like help with:_____
_____
How did you become aware of this issue?_____
_____
To what extent does this effect your daily life?_____
_____
How do you hope craniosacral therapy can help you?_____
_____
Other therapies you are currently active in: _____

Health History - *(circle any that apply)
Cancer_____ Concussion _____ Diabetes _____
High Blood Pressure _____ Heart Disease _____ Immune System Dysfunction_____
Meningitis_____Thyroid Disease _____ Seizures _____
Stroke/Aneurysm _____ Spinal Fluid Taps_____

*Is there any possibility of current hemorrhaging, blood clots, or tearing/puncture of your spinal meninges? Y ___N ___

Please list any significant:

Traumas_____

Surgeries_____

Major Dental Work_____

Birth History Problems (prolonged labor, C-section, premature, forceps/suction)_____

Allergies _____

_____

*Are you taking any blood thinning medications? Y ____ N ___

*Are you taking any blood pressure medications? Y ____ N ___

Nutrition/Exercise

Please describe your daily diet:

morning: _____

midday: _____

evening: _____

*What nutritional supplements are you currently taking? _____

_____

*What medications are you currently taking? _____

_____

Please indicate usage per day or per week:

cigarettes _____

alcohol_____

drugs_____

coffee_____

tea (caffeinated)_____

soft drinks_____

sugar_____

Do you have a regular exercise program? Please describe: _____

_____

Please circle any symptoms you experience or conditions which apply to you:

Musculoskeletal
Neck pain
Back pain
Knee pain
Shoulder pain
Hand/wrist pain
Foot/ankle pain
Nightsweats
Bleed or bruise easily
Strong thirst
Fatigue
Sudden energy drops
time of day_____
Poor sleep
Tremors
Poor Balance
Edema
Joint/bone problems
Torn tissues
Muscle pain/weakness
Other_____

Skin
Rashes
Itching
Eczema
Oozing
Pimples
Dry skin/scalp
Recent Moles
Change in hair/skin
Other _____

Head/Eyes/Ears/Nose/Throat
Headaches
where_____
when_____
Migraines
Dizziness
Lightheadedness
Earache
Discharge from ear
Poor hearing
Ringing in Ears
Blurry Vision
Double vision
Eye pain
Excessive tearing
Squinting
Sore/tired eyes
Aversion to flashing lights
Facial pain
Nose bleeds
Nasal discharge
Snoring
Grinding teeth
Teeth problems
Recurrent sore throat
Difficulty swallowing
Hoarseness
Tonsillitis
Swollen glands
Sores on mouth/lips
Other _____

Cardiovascular
Aneuryism
Pacemaker
High Blood pressure
Low blood pressure
Chest discomfort/pain
Heart palpitations
Cold hands/feet
Swelling of hands/feet
Blood clots
Spider veins
Fainting
Other_____

Neurological
Seizures
Nerve damage
Paralysis
Stroke
Sleep disorder
Concussion
Vertigo
Lack of coordination
Other_____

Respiratory
Difficulty breathing
Pain with breathing
Shallow breathing
Shortness of breath
Other _____

Digestion
Nausea
Vomiting
Heartburn
Indigestion
Abdominal pain/cramps
Bloody stools
Constipation
Gas
Other_____

Genito-urinary
Pain when urinating
Kidney stones
Blood in urine
Loss of balance
Poor memory
Difficulty in concentrating
Other_____

Immune System
Recurring infections
Itching
Rashes
Ongoing inflammation
Auto immune disorders
Other_____

Behavioral
Vacant
Moody
Easily susceptible to stress
Anxiety
Panic attacks
Depression
Fear
Other_____

Please note the severity of your problem right now by placing an X on the line.

I----------I

No problem Worst imaginable

Please note the greatest degree of severity of your problem within the last week. (Use X)

I----------I

No problem Worst imaginable

Comments:_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else you would like me to be aware of?

_____

_____

_____