NeuroMuscular
CranioSacral Therapy

NeuroMuscular Pain and Wellness Center
Patient Intake Form

Personal Information

Name _____ Phone _____

Address _____

City/State/Zip _____ DOB _____

Occupation _____

Email _____

Emergency Contact _____Relationship_____

Phone _____

How did you hear about us? _____

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

Medical Information

☐Cancer ☐Arthritis ☐Diabetes ☐Joint Replacement(s)

☐High/Low Blood Pressure ☐Neuropathy ☐Fibromyalgia ☐Stroke ☐Heart Attack

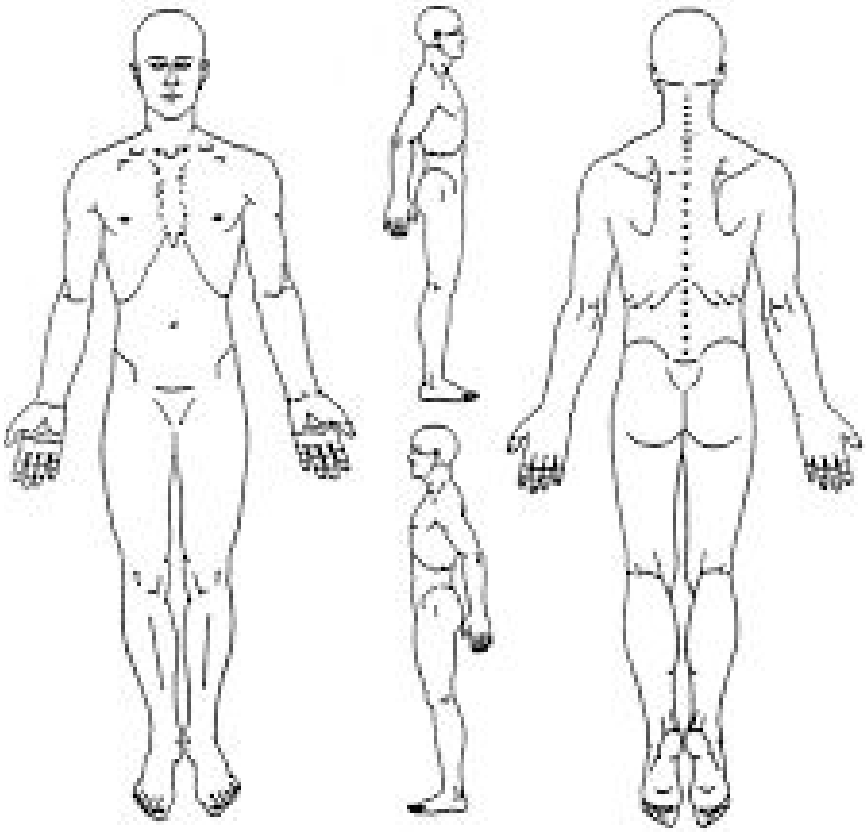
☐Kidney Dysfunction ☐Blood Clots

Explain any conditions you have marked above:_____

_____

What are your goals for this treatment session?_____

Please circle any areas of discomfort



By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____