BioWavz of Central Indiana Biodynamic Craniosacral Therapy Intake Form

Name:_____Date:_____

Address:_____DOB:_____Age:_____

City/State/Zip:_____Gender:_____

Cell/Text Phone:_____Email:_____

Marital status:_____(Women) Number of pregnancies:_____Ages of children:_____

Occupation:_____Do you enjoy your job/career?_____

Support / Resources (what you do to recharge yourself):

Medical history:

Medications / Supplements:

Accident history:

Surgical history:

Emotional / Stress situations:

Significant Family Medical History:

Reason for this visit:

Other practitioners you are seeing:

How did you find out about us? or referred by _____

Please fill out other side

Please mark what you are currently experiencing with a 1-10 concern if applicable.

Blood pressure (Low) (High) _____	Headaches _____	Energy levels _____
Seizures _____	Anxiety _____	Fluid retention _____
Allergies _____	Ringing in ears _____	Stroke _____
Eyes _____	Brain (TBI/Concussion) _____	Weight changes (gain) _____
Shoulders _____	Brain (surgery) _____	Weight changes (loss) _____
Legs _____	PTSD _____	Use prescription drugs _____
Bladder _____	Nausea _____	Use recreational drugs _____
Dizziness _____	Ears _____	Use CBD oil _____
Jaw _____	Neck _____	Use homeopathy _____
Arms _____	Feet _____	Sinus _____
Hips _____	Bowels _____	Epilepsy _____
Heartburn _____	Gallbladder _____	Swelling _____
Stomach _____	Asthma _____	Sleep problems _____
Indigestion _____	Vomiting _____	Liver _____
Rashes _____	Fainting _____	Lungs _____
Elbows _____	General back pain _____	Heart _____
Lower back _____	Hand _____	Skin _____
Mid back _____	Joint _____	Hernias _____
Upper back _____	Coughing _____	Smoker _____
Intestines _____	Teeth _____	Vape _____
Colic (child)	Bruising _____	Osteoarthritis _____
Nursing (child)	Injury_____ _____	Rheumatoid arthritis _____
Attachment (child)	Chronic inflammation _____	MS (Multiple sclerosis) _____
Bonding challenges (child)	Sciatica _____	Vertigo _____
Addiction _____	Hyperactivity _____	Other_____ _____
Long COVID _____	Central nervous system _____	Other_____ _____

I have answered honestly and to the best of my knowledge:

Client Signature: _____ Date :_____

Have you had or have TBI, brain surgery, other brain trauma? Explain_____

_____

_____