The Yoga: Cranio Intake Form

Name:
DOB:
Address:
Telephone:
Email:

Accidents, Surgery or Trauma: Let me know very brief details, rough dates & any lingering effects:

Health Issues & Concerns - Tell me briefly about your medical history and any health concerns you have just now:

Medication & Allergies? Please let me know of any details:

Life Style - please let me know a little about how your life style affects your physical and mental health:

Briefly, why are you seeking cranio treatment just now?

Pregnancy & Birth: Let me know how this went for you, your own, and that of any children:

Have you had cranio sacral therapy before?

Baselines

- Physical health 1-10 (1= the lowest health you can imagine, 5=variable or middling, 10=the most excellent health you can imagine)
- Emotional health 1-10 (1= the lowest health you can imagine, 5=variable or middling, 10=the most excellent health you can imagine)
- Spiritual Satisfaction & Meaning 1-10 (1= least meaningful life imaginable, 5=variable or middling, 10=the most meaningful imaginable)
- Pain levels 0-10 (0= the most pain you can image, 5=intermittent or ongoing low level pain, 10= no pain)

Emergency contact:
Signed:
Date: