Tidal Body Craniosacral Therapy

Sarah Mull, LMT, CCST

# General Health History

Patient's name: _____ Date of Birth:_____

Parent name(s): _____

Address:_____

Phone#:_____ Email address:_____

Emergency Contact: _____ phone #: _____

Would you like to receive appointment reminders? **Text** **Email** **None**

Who can I thank for referring you? _____

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**Are you currently seeing a doctor? Y N** What is the diagnosis? _____

Was massage prescribed for you? Y N

**What was patient's birth experience?** _____

_____

**Allergies? Y N** _____ **Skin conditions? Y N** _____

**Do you currently take any medications? Y N** _____

**Please list any previous injuries, illness, or surgeries:** _____

_____

**How do you play? (sports, hobbies, etc)?** _____

_____

**How is your diet? What do you like/not like?** _____

# Tidal Body Craniosacral Therapy

**Have you received massage or bodywork before? Y N**

What kind and what for? _____

What did you like? _____ What didn't you like? _____

**What would you like to gain from receiving bodywork today and in the future?** _____

_____

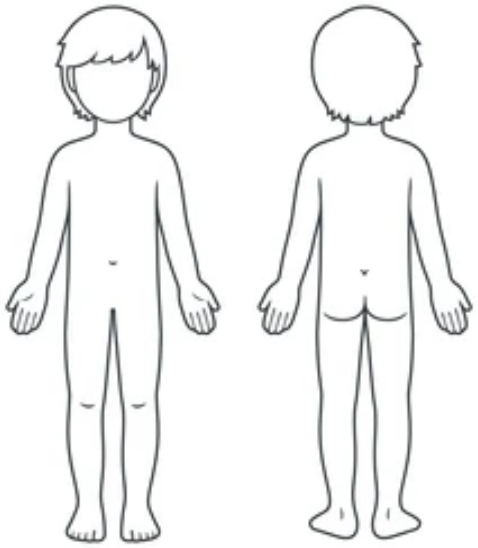
**How have you been feeling in general?**

_____

_____

**Please mark areas of:**

stress (S)
pain/discomfort (P)
numbness/weakness (N)
inflammation (I)



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*I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, or pain, treatment of injury, or for increasing circulation. I agree to inform my practitioner any time i feel that my well-being is being compromised.*

*I understand that LMT's do not diagnose illness or any mental disorder, nor do they prescribe medical treatment. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it recommended that I see a primary health care provider for that service.*

*I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status. I understand that these health records are confidential, and authorize Sarah Mull, LMT, CCST, as my massage therapist, to contact my health care providers if necessary.*

*If necessary, I authorize Sarah Mull, as my massage therapist, to release any medical records to insurance or legal representatives for billing purposes. I understand and agree to the fees and billing policies of my massage therapist, including a no-show/late cancellation (less than 24 hours) fee of $50 to be paid on the date of the scheduled service.*

**Parent/Custodian Signature** _____ **Date** _____