Tidal Body Craniosacral Therapy

Sarah Mull, LMT, CCST

Personal Information

Full name: _____ Date of Birth:_____

Address:_____

Phone#:_____ Email address:_____

Occupation:_____ Age:_____

Emergency Contact: _____ phone #: _____

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

Who can I thank for referring you? _____

General Health History

Frequently, accumulation of stress can lead to health problems and influence our ability to heal. Please be as accurate as possible, as this can help your understanding of your current state of health.

Are you currently seeing a doctor? **Y** **N** For what?_____

Are you pregnant or trying? **Y** **N** Previous pregnancies: Number: _____

Date(s): _____

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

Do you have any allergies? **Y** **N** _____

Do you have any skin conditions? **Y** **N** _____

Have you ever had any accidents/injuries (auto, work, play, etc)?

Type:_____ Age:_____ Treatment:_____

Type:_____ Age:_____ Treatment:_____

Type:_____ Age:_____ Treatment:_____

Have you ever had surgery? **Y N**

Type:_____ Date:_____

Type:_____ Date:_____

Type:_____ Date:_____

Do you exercise? **Y N** Type and frequency: _____

_____

How would you describe your diet? _____

Do you have a history of abuse or trauma? _____

_____

Please list any previous illnesses or injuries:

Muscular (strains/stiffness)_____

Skeletal (breaks) _____

Head Injury/TMJ/orthodontics _____

Circulatory _____

Digestive _____

Nervous _____

Reproductive/Urogenital _____

Infectious Disease _____

Cancer _____

Current Health Concerns

How have you been feeling in general? _____

What are your top health concerns? Please list according to severity. Include when they started and how you are addressing them.

1. _____

2. _____

3. _____

Have you received craniosacral therapy or bodywork before? **Y N**

What kind and how often? _____

What did you like? _____

What didn't you like? _____

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

_____

Please mark areas of:

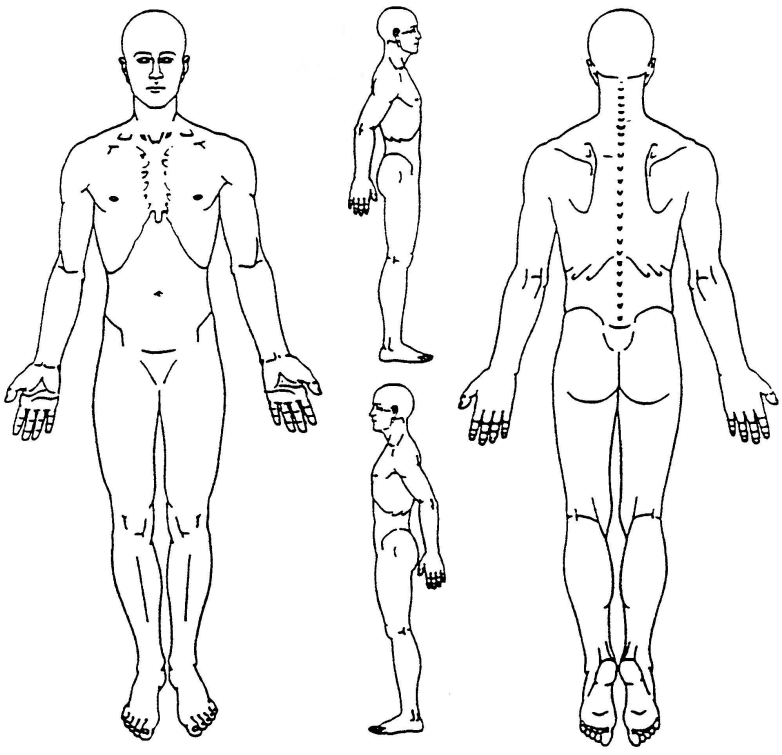
Tension (T)
Pain (P)
Numbness/weakness (N)
Inflammation (I)

Where do you want special attention? _____

_____

Where do you not want to be touched? (*breasts and genitals are never touched*) _____

_____



112 Ohio St. Suite #222 · Bellingham, WA

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 massage therapists do not diagnose illness or any mental disorders; nor do they prescribe medical treatment. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary care provider for that service.

I have stated all medical conditions that I am aware of and will update my 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, LMT, CCST, 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.

Patient Signature _____ **Date** _____

Parent/Custodian Signature _____ **Date** _____