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CranioSacral Visceral Manipulation
Reiki
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Manual Therapy Intake Form

Personal Information

Name: _____ Date _____

Date of Birth: _____/_____/_____ Sex : _____Male _____Female

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Email Address: _____

Occupation: _____

In case of emergency, please notify:

Name _____ Telephone # _____

Relationship: _____

What are your goals for this session? _____

_____

_____

Health Information

Are you currently under a physician care for an acute or chronic illness? ____ No ___ Yes

If yes please explain: _____

Do you have any infectious disease? ____ N ____ Y

If Yes, please describe: _____

Are you currently taking any prescribed medication, over the counter medication, dietary supplements, vitamins or herbs? ___ No __ Yes. If yes please list names and reason for medication: _____

_____

Are you wearing contact lenses? ___ Dentures? ___ Hearing aid? ____ Peacemaker?

____ Transdermal patch? ____ Catheter?

Do you experience stress in your work, family, or other aspect of your life? ___ No ___ Yes

Do you have children? Age? _____

If yes, how do you think it has affected your health?

Muscle tension _____ Anxiety ____ Insomnia ____ Irritability ____ Sadness _____

Issue Concentration ____ Other _____

_____

_____

_____

Family History

Please check any occurrence of the following in your family's history.

___ Heart Disease
___ Diabetes
___ Arthritis
___ Cancer
___ Osteoporosis
___ Alzheimer's
___ Mental Illness
___ Thyroid condition
___ Liver condition
___ Kidney condition
___ Respiratory disease

Check the following conditions that apply to you, **past and present**. Add your comments to clarify the condition. Please use back of form to explain all checked conditions.

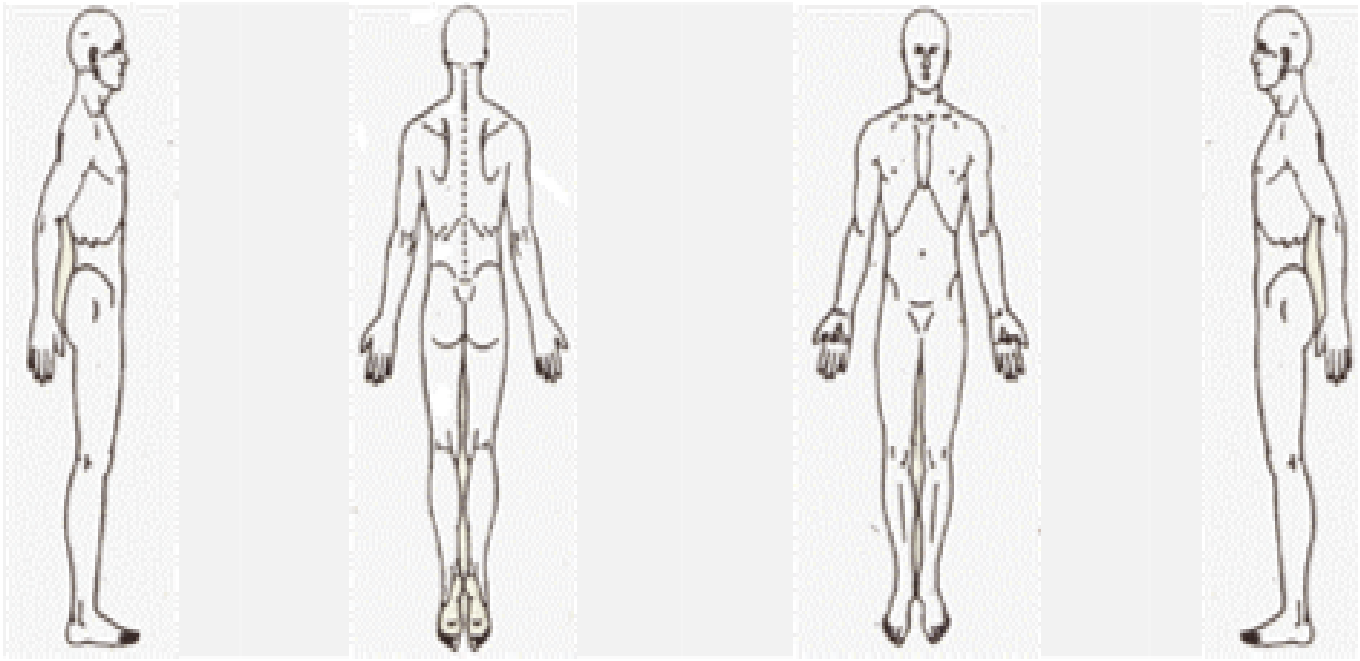
Musculo-Skeletal

Do you have any difficulty lying on your front, back, or side? ____ No ____ Yes
If yes, please explain: _____

Do you sit for long hours at a workstation, computer, or driving? ____ No ____Yes
If yes, please describe: _____

Do you perform any repetitive movement in your work, sports, or hobby? ___ No ____ Yes
If yes, please describe: _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain? or other discomfort? ____ No ____ Yes
If yes, please identify: indicate with an (X) the areas in which you are feeling discomfort:



___ Headaches
___ Joint stiffness/swelling
____Spasms/cramps
____ Broken/fractured bones
____ Strains/sprains
____ Back, hip pain
____ Shoulder, neck, arm, hand pain
____ Leg, foot pain
____ Chest, ribs, abdominal pain
____ Problems walking
____ Jaw pain/TMJ
____ Tendonitis
____ Bursitis
____ Arthritis
____ Osteoporosis
____ Scoliosis
____ Bone or joint disease
Other: _____
_____
_____
____

Circulatory and Respiratory

____ Anemia
____ Shortness of breath
____ Dizziness / Fainting
____ Cold feet or hands
____ Cold sweats
____ Swollen ankles
____ Varicose veins
____ Blood clots
____ Stroke
____ Heart condition
____ Allergies
____ Sinus problems
____ Asthma
____ High blood pressure
____ Low blood pressure
____ Lymphedema
Other: _____

Skin

Do you have any allergies to oils, lotions, or ointments? ____ No ____Yes

If yes, please explain: _____

Do you have sensitive skin? ____ No ____Yes

____ Rashes
____ Allergies
____ Athlete's Foot
____ Warts
____ Moles
____ Acne
____ Cosmetic surgery
____ Decubitus Ulcer
Other: _____
_____
_____

Digestive

____ Nervous stomach
____ Indigestion
____ Constipation
____ Intestinal gas/bloating
____ Diarrhea
____ Diverticulitis
____ Irritable bowel syndrome
____ Crohn's Disease
____ Colitis
____ Adaptive aids
____ Hepatitis / Jaundice
Other: _____

Nervous System

____ Numbness/tingling
____ Twitching of face
____ Fatigue
____ Chronic pain
____ Sleep disorders
____ Ulcers
____ Paralysis
____ Herpes/shingles
____ Cerebral Palsy
____ Epilepsy
____ Chronic Fatigue Syndrome
____ Multiple Sclerosis
____ Muscular Dystrophy
____ Radiculopathy
____ Spinal cord injury
Other: _____
_____

Reproductive System

Pregnancy:
____ Current
____ Previous
____ PMS
____ Menopause
____ Pelvic Inflammatory Disease
____ Endometriosis
____ Hysterectomy
____ Fertility concerns
____ Prostate problems
Other: _____
_____
_____

Other

____ Loss of appetite
____ Forgetfulness
____ Depression
____ Difficulty concentrating
____ Drug use
____ Alcohol use
____ Nicotine use
____ Caffeine use

____ Hearing impaired
____ Visually impaired
____ Burning upon urination
____ Bladder infection
____ Eating disorder
____ Diabetes
____ Fibromyalgia
____ Post/Polio Syndrome

____ Cancer
Other congenital or acquired disabilities
_____
Surgeries _____
Other: _____
_____

I, _____, (client) have completed the form to the

best of my knowledge and I shall take it upon myself to inform the therapist of any changes.

I understand that Delia Ahouandjinou LMT, does not diagnose illness or disease or other medical, physical or emotional disorder, nor prescribe any medications/treatments. I acknowledge that I am responsible for consulting a qualified physician for any ailments that I may have. If necessary, I allow Delia to discuss with my health care provider the appropriateness of bodywork for my condition.

If I experience any pain or discomfort during this session, I agree to immediately inform the therapist so that the pressure and/or methods can be adjusted to my comfort level. The therapist reserves the right to refuse services for any reason of safety.

Full payment is required at time of service.
I understand that I am responsible for payment if I cancel with less than 24 hours notice.

Signature: _____ Date:_____

Signature of parent/guardian: _____ Date:_____
(If patient is a minor)