

New Client Form

Name: _____ DOB _____

Address: _____ City, State, Zip _____

Phone #: _____ Email: _____

Occupation: _____ Other Activities _____

Emergency Contact: _____ Phone #: _____

Medications Being Taken _____

Please indicate any of the following conditions and surgeries that apply:

blood clots headaches allergies arthritis tendonitis cancer
teeth grinding TMJ abnormal skin condition varicose veins blood clots
heart/circulation problems joint surgery/replacement high / low blood pressure
neck / back injuries diabetes fibromyalgia numbness sprains strains recent injuries

Explain Any Conditions You Have Marked Above: _____

Areas of Complaint, Pain or Tension: _____

Have you had massage, craniosacral therapy/ energy work before? ____ Was it helpful? ____

How did you find out about this service? _____

Please circle areas you wish to be avoided:

head shoulders face back glutes legs feet upper chest neck abdomen arms hands

I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. Draping will be used. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

If I am uncomfortable for any reason, I may ask to end the session.

Client Signature:

Date:

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Evaluation:

Head _____ *back*
Neck _____ *quads*
Shoulders _____ *hips*

Range of Motion:

CranioSacral Rhythm

Symmetry _____ *Amplitude* _____
Quality _____ *Rate* _____
Amplitude _____
Rate _____

CranioSacral System:

Cranial Base _____
Occiput _____
Sphenoid _____
Parietals _____
Frontal _____
Temporals _____
Vomer flexion/ext. sucking _____
Sacrum _____
Dural Tube _____

Fascia and Diaphragms:

Pelvic _____
Lower Extremities _____
Respiratory _____
Thoracic _____

Upper

Extremities _____

Other Observations: Fontanels, Reflexes, Viscera:

Summary:

*Response to Treatment: Change in CSR, Vault Hold, Fascial Mobility, Sucking
Goals and Recommendations:*