ROSE FUSAE DUHIG
Craniosacral Therapy & Energy Alignment Massage Therapy
Client Intake Form

Last Name:_____ First Name:_____ DOB:_____

Street Address:_____ City, State, Zip:_____

Home Phone:_____ Cell:_____

Work Phone:_____ How were you referred?_____

Text? ☐Yes ☐No Age: Sex: ☐Male ☐Female

What depth of pressure do you prefer? ☐Light ☐Medium ☐Firm

In case of emergency, contact:_____ Phone:_____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐Yes ☐No Do you have diabetes?

If Yes, are you insulin dependent? ☐Yes ☐No

Is your insulin "Well Managed?" ☐Yes ☐No

☐Yes ☐No Do you have allergies (ie: almond/nut, apricot/fruit, etc)_____

☐Yes ☐No Do you experience frequent headaches?

☐Yes ☐No Do you suffer from arthritis?

☐Yes ☐No Do you suffer from joint pain?

☐Yes ☐No Do you suffer from epilepsy or seizures?

If Yes, Last seizure? _____ Medications:_____

☐Yes ☐No Do you have varicose veins?

☐Yes ☐No Do you have osteoporosis? Date of diagnosis?_____

☐Yes ☐No Do you bruise easily?

If yes, are you on Coumadin, aspirin therapy, other? _____

☐Yes ☐No Do you have high blood pressure? If yes, medication? _____

If yes, is your high blood pressure well managed? ☐Yes ☐No

☐Yes ☐No Do you have cardiac or circulatory problems??

☐Yes ☐No Do you use nitroglycerin?

☐Yes ☐No Do you have any with you / where? _____

☐Yes ☐No Is your situation well managed?

☐Yes ☐No Do you suffer from back pain? Specify area: _____

☐Yes ☐No Do you have any numbness or stabbing pain anywhere?

If yes, have you seen a physician for the condition? ☐Yes ☐No

Do you have or are you wearing? ☐Dentures ☐Contact Lenses ☐Hearing Aid

☐Yes ☐No Are you or have you been trying to become pregnant?

****** 1st trimester pregnancies are contraindicated for massage and out of my scope of practice.***

☐ Yes ☐ No Are you sensitive to touch in any area? Where: _____

☐ Yes ☐ No Are you currently undergoing chemotherapy?

☐ Yes ☐ No Are you currently undergoing radiation? Where: _____

☐ Yes ☐ No Are you currently taking or applying any medication or OTC product that may adversely affect, you-the client, or myself, the massage professional through contact of the skin?

If yes, please describe: _____

☐ Yes ☐ No Have you had surgery? If yes, for what/when: _____

_____

☐ Yes ☐ No Have you been in an accident or suffered injuries in the past 2 years?

_____

☐ Yes ☐ No Have you had any broken bones in the past 2 years? _____

_____

CLIENT INTAKE FORM

☐ Yes ☐ No **CST clients** – Are you considering or currently seeking medical assistance for depression or undergoing a (past or current) traumatic life event?

If yes, please inform your doctor of your current bodywork treatment:

Date informed: _____

If No, bodywork combined with professional talk therapy is a very useful tool & a suggestion by your bodywork professional. Once understood, please initial: _____

For massage/bodywork professional: _____.

If there are ANY other considerations I should be made aware of, please indicate here:

_____

_____

_____

Signature: _____ Date: _____

PLEASE IDENTIFY ON THE DIAGRAMS BELOW AREA'S OF DISCOMFORT OR TOPICS FOR DISCUSSION: