Initial In-take Form

Name

Date of Birth

Email and Phone Number

Emergency Contact

Primary Health Care Provider, Phone Number

Referring professional (if applicable)

- [ ] I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Birth gender and identifying gender

Occupation/Employer

Past surgeries (list and date)

Current medications (prescription and over-the-counter):

Past Medical History: Have you ever been told you have any of the following? (check all that apply)

- [ ] History of cancer
- [ ] Allergies
- [ ] Ulcers
- [ ] Osteoporosis
- [ ] Heart issues/Angina/Chest Pain
- [ ] Thyroid problems
- [ ] Fibromyalgia
- [ ] High Blood Pressure
- [ ] Kidney disease
- [ ] Hepatitis
- [ ] Rheumatoid arthritis
- [ ] Lung problems
- [ ] Asthma
- [ ] Immunosuppression
- [ ] Diabetes
- [ ] Osteoarthritis
- [ ] Seizures/Epilepsy
- [ ] Anemia
- [ ] Depression
- [ ] Stroke

Currently, are you experiencing any of the following? Check all that apply: (check all that apply)

- [ ] Fevers/chills/sweats
- [ ] Changes in appetite
- [ ] Poor balance/falls
- [ ] Difficulty swallowing
- [ ] Unexplained weight loss
- [ ] Pelvic pain
- [ ] Headaches
- [ ] Depression
- [ ] Numbness/tingling
- [ ] Shortness of breath
- [ ] Night pain
- [ ] Dizziness
- [ ] Nausea/vomiting

- [ ] Changes in bowel or bladder function

How have you been sleeping at night? (check all that apply)

- [ ] Fine
- [ ] Disturbed
- [ ] Only with medication

What brings you ease, support and relaxation during the week?

What gives you positive energy?

Reason for Visit

What date (approximately) did your present symptoms start?

How? (gradually, suddenly, injury, surgery)

How have your symptoms changed? (check all that apply)

- ☐ Getting better
- ☐ Staying about the same
- ☐ Getting worse

What makes your symptoms better?

What makes your symptoms worse?

Have you had an x-ray, MRI, or other testing for this problem? (please specify)

What treatments have you received for this problem so far?

Pain Scale (circle one)

0 (no pain)

1

2

3

4

5 (distressing pain)

6

7

8

9

10 (worst pain imaginable)

Functional Level (circle one)

0 (able to do everything)

1

2

3

4

5

6

7

8

9

10 (can't do anything)

What are your goals for therapy?

Have you received Biodynamic Craniosacral Therapy before? If so, when?

☐ I certify that the above medical information is correct to my knowledge.

☐ I authorize Shaina Cantino to communicate with my doctor and/or referring doctor as deemed necessary for beneficial treatment. I understand that my personal/medical information is confidential and will only be disclosed to 3rd parties with my consent.

☐ I understand that 24 hours notice is required for any cancellations or changes to my appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a fee of $50.