# Client Information Form

Name _______________________________________Phone ______________________

Address ________________________________________________________________

Birth date ____________ Who referred you? ______________________________

Physician ______________________ Emergency contact? ____________________

Have you ever had CranioSacral Therapy before? __________________________

Present Complaint ________________________________________________________

How long have you had it? ________________________________________________

Please mark an X on the pictures below where you have your symptoms.

Please check any of the following that apply and add details where needed:

| | | | |
|---|---|---|---|
| Medications | No | Yes | ______________________________ |
| Allergies | No | Yes | ______________________________ |
| Tobacco use | No | Yes | ______________________________ |
| Dentures | No | Yes | ______________________________ |
| Contacts | No | Yes | ______________________________ |
| Surgeries | No | Yes | ______________________________ |
| Auto Accidents | No | Yes | ______________________________ |

Anything else you want me to know about you? ____________________________

________________________________________________________________________

________________________________________________________________________

I agree to receive treatment for my body including Cranial Sacral Therapy (CST) and/or Visceral Therapy from Brenda Aufderhar, RN, LICSW. I understand that CST is not recommended if I may have a recent cranial fracture. I agree to contact Brenda Aufderhar if I have any questions or concerns after a treatment.

Signature____________________________________________Date ______________