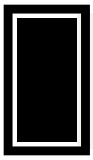

Virginia Wilke, CMT, RCST®
Craniosacral Therapy & Therapeutic Massage

Date: _____

First Name: _____ Last Name: _____

Address: _____ Home phone: _____

City: _____ State: _____ Zip: _____ Cell phone: _____

Email: _____ Gender: Male / Female

Occupation: _____ Date of Birth: _____

Emergency contact: _____ Phone: _____

Medical History

Have you ever experienced or been diagnosed with any of these conditions?

Past	**Current**		Past	**Current**	
( )	**( )**	AIDS / HIV+	( )	**( )**	High blood pressure
( )	**( )**	Allergies	( )	**( )**	Measles
( )	**( )**	Arthritis	( )	**( )**	Mental illness
( )	**( )**	Asthma	( )	**( )**	Mononucleosis
( )	**( )**	Back pain	( )	**( )**	Multiple sclerosis
( )	**( )**	Broken bones	( )	**( )**	Neck pain
( )	**( )**	Bursitis	( )	**( )**	Nerve damage
( )	**( )**	Cancer	( )	**( )**	Osteoporosis
( )	**( )**	Carpal tunnel syndrome	( )	**( )**	Pregnancy
( )	**( )**	Chronic stress or anxiety	( )	**( )**	PTSD
( )	**( )**	Concussion / head injury	( )	**( )**	Seizures / epilepsy
( )	**( )**	Depression	( )	**( )**	Spinal injury / whiplash
( )	**( )**	Diabetes	( )	**( )**	Stroke
( )	**( )**	Digestive / bowel problems	( )	**( )**	Tendonitis
( )	**( )**	Fibromyalgia / chronic fatigue	( )	**( )**	Thyroid disease
( )	**( )**	Headaches / migraines	( )	**( )**	TMJ pain / teeth grinding
( )	**( )**	Heart condition	( )	**( )**	Ulcers
( )	**( )**	Hemophilia	( )	**( )**	Varicose veins
( )	**( )**	Hepatitis	( )	**( )**	Other – specify below

List any other health conditions not listed above:

_____

List any recent surgeries:

_____

List any significant accidents and injuries:

_____

List any treatment or medications you are receiving (traditional and alternative):

_____

Emotional Health History

Please answer as much as you feel comfortable sharing. All information is kept strictly confidential.

How would you rate your **usual** stress level on a scale from 1–10? _____
(1 = low, 10 = high)

How would you rate your stress level **today** on a scale from 1–10? _____
(1 = low, 10 = high)

Difficult life experiences: Check one or both columns below, as appropriate, or leave blank.

Past	**Current**		Past	**Current**	
( )	**( )**	Physical abuse (known or suspected)	( )	**( )**	Divorce (self, parents, children)
( )	**( )**	Emotional abuse (known or suspected)	( )	**( )**	Loss of home / job
( )	**( )**	Sexual abuse (known or suspected)	( )	**( )**	Prolonged or unexpected grief
( )	**( )**	Suicidal feelings or thoughts	( )	**( )**	Compulsive eating, spending, etc.
( )	**( )**	Suicide attempts	( )	**( )**	Excessive worries about health
( )	**( )**	Panic attack	( )	**( )**	Nervous breakdown
( )	**( )**	Phobias	( )	**( )**	Eating disorders
( )	**( )**	Depression	( )	**( )**	Sexual dysfunction
( )	**( )**	Insomnia / other sleep problems	( )	**( )**	Pre/menstrual or menopausal difficulties
( )	**( )**	Nightmares / recurrent dreams	( )	**( )**	Birth trauma
( )	**( )**	Death of loved one (human or animal)	( )	**( )**	Other (list below)

Any other conditions / experiences not listed above?

_____

Is there anything else about your emotional or mental history or well-being that you think I might need to know?

_____

_____

Support in Your Life

What do you enjoy? What comforts you? What supports you in your life?

_____

_____

Treatment Goals

What would you most like help with? What are you hoping to get from the session(s)?

_____

_____

I acknowledge that neither craniosacral nor massage therapy is a substitute for medical examination, diagnosis, or treatment or for qualified mental health care. Nothing said or done by a craniosacral or massage therapist should be misconstrued as such. Because bodywork should not be performed in the case of certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I take full responsibility for informing my practitioner of any changes in my health status. Understanding all of this, I give my consent to receive care.

_____ _____
Signature Date