The Art of Healing Intake Form

Date: _____ Referred by: _____

First, Last Name: _____ DOB: _____ Age:_____

Address: _____ City: _____State: _____Zip_____

Phone: _____ Email: _____

Emergency Contact Name/Phone: _____

Reason for visit: _____

Intention for the Session: _____

Allergies: _____

Medications/OTC medications/Supplements: (names only)

Medical History: (diagnosis only)

Surgical History:

Birth History: (circle all that apply)

Preterm Full term Overdue Birth: Vaginal C Section

Vacuum Extraction Forceps Other Birth Injury None

Post delivery complications: _____

Size at Birth: _____ Breast Fed Formula Fed

# of Siblings: _____ Your Birth Order:_____ Vaccinations: _____

Children:

# of Live Birth(s)_____ # of Abortion(s)_____ # of Miscarriage(s)_____

Self-Evaluate the following:

Sleep: _____ Average hours/night: _____ Explain: _____

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When you wake in the AM, how do you feel? _____

Nutrition: (Shortly describe your average day)

_____

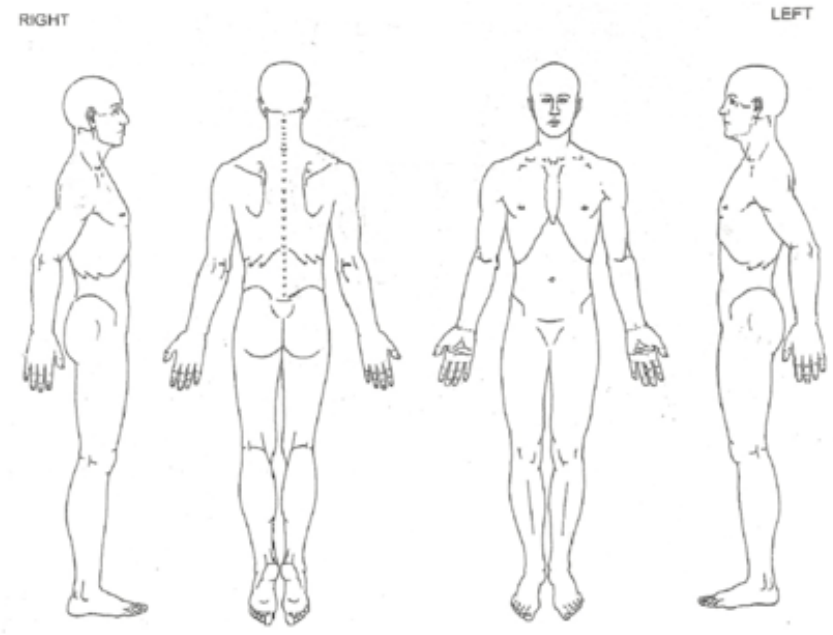
_____

Exercise: _____

Self-evaluate the following topics on a scale of 0-5, 5 being the best:

Physical: _____ Emotional: _____ Mental: _____ Spiritual: _____

Please mark areas of concern:



Pain (rate overall pain on scale of 0-10): _____ Describe: _____

Do you have any of the following contraindications to receiving CST: (circle all that apply)

Brain bleed Brain clips VP Shunts Chiari Malformation Brain Aneurysm

Seizure Disorder Pacemaker/Defibrillator