



# Cranio-Sacral Therapy Pediatric Intake Form

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Parent(s)/Guardian: Mother \_\_\_\_\_ Father \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Contact's Phone Number: \_\_\_\_\_ Contact's Email: \_\_\_\_\_

Please List any **Life Threatening Allergies:** \_\_\_\_\_

Referred to Dr. Emily Telfair by: \_\_\_\_\_

### Current Health Care Team:

Primary Care Physician: \_\_\_\_\_ Office Number: \_\_\_\_\_

Specialist Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Office Number: \_\_\_\_\_

*Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):*

Practitioner Name: \_\_\_\_\_ Office Number: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Office Number: \_\_\_\_\_

### Primary Health Concerns: *Please list you primary health concerns in order of importance.*

| <u>Concern</u>      | <u>Onset</u>     | <u>Frequency</u>    | <u>Severity</u>        |
|---------------------|------------------|---------------------|------------------------|
| <i>Ex: Headache</i> | <i>June 1978</i> | <i>4 times/week</i> | <i>mild/mod/severe</i> |
| 1. _____            | _____            | _____               | _____                  |
| 2. _____            | _____            | _____               | _____                  |
| 3. _____            | _____            | _____               | _____                  |

Have your child ever received cranio-sacral therapy? Y / N      If yes, when his/her last treatment? \_\_\_\_\_

What are your goals for this visit?

\_\_\_\_\_  
\_\_\_\_\_

List all current medications, supplements, herbal remedies, etc: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(OVER PLEASE)

**PERSONAL MEDICAL HISTORY**

List and include dates if possible:

- Surgeries: \_\_\_\_\_
- Accidents/Injuries: \_\_\_\_\_
- Major Illnesses/Hospitalizations: \_\_\_\_\_

Please mark any of the following conditions you have now or have *significant history* of in the past.

**General**

| Current                  | Past                     | Comments                 |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain: _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Disturbance: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue: _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____             |

**Muscles and Joints**

| Current                  | Past                     | Comments                      |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bone or Joint Disease: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis: _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken Bones: _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis/Bursitis: _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis: _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis: _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Disc Problems: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus: _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sprain/Strain: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain/TMJ: _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck/Shoulder/Arm Pain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Low back Pain: _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Ankle Pain: _____        |

**Nervous System**

| Current                  | Past                     | Comments                         |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head injuries/Concussions: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Ringing in ears: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Sciatica/Shooting pains: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched Nerve: _____             |
| <input type="checkbox"/> | <input type="checkbox"/> | Bell's Palsy: _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                     |

**Endocrine System**

| Current                  | Past                     | Comments                 |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Condition: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____             |

**Respiratory/Cardiovascular**

| Current                  | Past                     | Comments                          |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Condition: _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots: _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | High/Low Blood Pressure: _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke: _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat: _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Circulation: _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Edema/Swollen Ankles: _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain/Short of Breath: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: _____                     |

**Digestive/Elimination System**

| Current                  | Past                     | Comments                          |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Diarrhea: _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas/Bloating: _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastric Ulcers: _____             |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder/Kidney Dysfunction: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                      |

**Reproductive**

| Current                  | Past                     | Comments                  |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual problems: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____              |

**Other**

| Current                  | Past                     | Comments              |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/Stress: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use: _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Drugs: _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol: _____        |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____          |

I understand that CranioSacral therapy is not a substitute for standard medical care and I have indicated all known medical conditions for my child above. I will alert the practitioner to any changes in my child's health status. I hereby give consent for my child to receive CranioSacral therapy with an understanding of the risks and benefits. I understand that there is no stated guarantee for effectiveness of treatment. I understand that my child's records will be kept in strict confidence.

**PAYMENT POLICIES**

Full payment is due at the time of service. Dr. Telfair requests 24-hours notice for canceling or rescheduling appointments. For any visits canceled with less than 24-hours notice, the client will be charged half of the original visit fee except in the case of family or medical emergency. This charge will be applied to the following visit or billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_