Nadine Saxton
THERAPY SERVICES

Somatic/CranioSacral Therapy Medical History Form

Name: _____ Date: _____

Address: _____ email _____

Postal Code: _____ Phone : (H) _____ (W) _____ C

Occupation: _____ # Hrs/Day: _____

Date Of Birth _____ Weight: _____ Height: _____

Referred By: _____ email _____

Main Reason For Coming: _____

Medical Doctor;

Other Health Care : ☐ Chiropractor ☐ Naturopath ☐ Shiatsu ☐ Physiotherapy
☐ Massage ☐ Other (Please Specify) _____

Regular Exercise: (I.e. 3 times/wk) _____

Please answer the following and indicate if past &/or Present

Arthritic Problems:	☐ No	☐ Yes	_____
Bowel/ Bladder Problems:	☐ No	☐ Yes	_____
Circulatory Problems: (Arteriosclerosis, Stroke, Varicose Veins, Hemophilia, Etc	☐ No	☐ Yes	_____
Digestive Disorders:	☐ No	☐ Yes	_____
Earaches:	☐ No	☐ Yes	_____
Sinus/Allergies:	☐ No	☐ Yes	_____
Headaches/Migraines:	☐ No	☐ Yes	_____
Heart Problems:	☐ No	☐ Yes	_____
High/Low Blood Pressure:	☐ No	☐ Yes	_____
Respiratory Problems:	☐ No	☐ Yes	_____
Skin Problems/Sensitivities:	☐ No	☐ Yes	_____
Stiff/Painful Joints:	☐ No	☐ Yes	_____
Pain/Tension Back/Neck:	☐ No	☐ Yes	_____
Surgery/hospitaliztion:	☐ No	☐ Yes	_____
Accidents/Fractures:	☐ No	☐ Yes	_____
Diabetes:	☐ No	☐ Yes	_____
Cancer:	☐ No	☐ Yes	_____
Menstrual/Menopausal Disorders / Pregnancies:	☐ No	☐ Yes	_____
Medication:	☐ No	☐ Yes	

Anything else _____

Please use back of page _____

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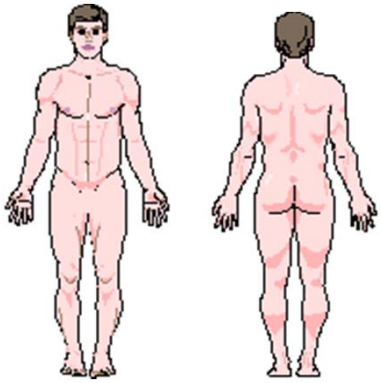
Please Shade Area(s) In Which You Have Pain /Tension



Client's Consent To Treatment

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the therapist to stop or alter treatment or to clarify the reason for the particular technique being used. I understand I have responsibilty and agency over myself.
I will discuss my ongoing experiences. I understand that emotions may arise as I am participating in treatment. Information disclosed by me in therapy is confidentional. Exceptions to confidentiality include child, elder, and dependent adult abuse: expressed threats of violence towards a victim: legal subpoena.
As a necessary element of Therapist self care, confidential information may be discussed with a supervisor and peer supervision including this therapist's partner in practice. No identifying information such as my name will be used

Client's Signature: _____ Date _____