CranioSacral Institute of Michigan, LLC 51850 Dequindre Rd., Suite 1, Shelby Twp, MI 48316

Name: ______________________ Birthdate__________ Date______________

Address:______________________ ______________________
City State Zip

Home Phone:(____)______________ Work (____)______________Ext_______ Cell (_____)______________

Best time and place to reach you______________________

Home Phone (_____)______________ Work Phone(_____)______________

CONTACT IN CASE OF EMERGENCY:______________________ Relationship______________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Whom may we thank for referring you?______________________

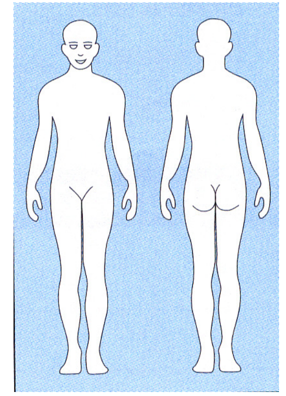
Would you like to receive our newsletter via email? Yes/no Email address: ______________________

Reason for Visit______________________

When did your symptoms appear?______________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

*Mark an **X** on the picture where you continue to have pain, numbness, or tingling.*



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?______________________

Is it constant or does it come and go?______________________

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ CranioSacral Therapy ☐ None ☐ Other______________________

Exercise:	☐ None	☐ Moderate	☐ Daily	☐ Heavy	
Work Activity:	☐ Sitting	☐ Standing	☐ Light Labor	☐ Heavy Labor	☐ Mixed
Habits:	☐ Smoking Packs/day:_____		☐ Alcohol Drinks/Week:_____		
	☐ Coffee/Caffeine Cups/Day:_____		☐ High Stress Level Reason____________		

Injuries/Surgeries	Description	Date
Falls	______________________	__________
Head Injuries	______________________	__________
Broken Bones	______________________	__________
Surgeries	______________________	__________
Birth Trauma/Injury	______________________	__________

Do you have any pins or plates? ______________ if yes, where? ______________________

Medication(s)	Allergies	Vitamins/Herbs/Minerals