Optimal Wellness Solutions

2489 Rice Street, Suite 130
Roseville, MN 55113
651-340-1233

CLIENT INTAKE FORM – STRICTLY CONFIDENTIAL

Name _____ Date _____

Address _____

City _____ ZIP _____ Date of Birth _____

Telephones: Home _____ Work _____ Cell _____

Email Address _____

Person to Contact in an Emergency _____

Relationship _____ Phone _____

Current Doctor _____ Other Specialist _____

Current Prescription Medicines _____

_____

Current Complimentary Therapies / Supplements _____

_____

Eating Habits / Diet _____

_____

Daily Intake: Water _____ Caffeine _____ Alcohol _____ Cigarettes _____

Normal Excercise Routine _____

_____

Mark the following areas of disease or symptoms. C = Current, P = Past, or R = Recurring Explain if necessary.

Psychological	**Endocrine**	**Cardiovascular**	**Reproductive**
Depression	Adrenal Insufficiency	Agnia	Sexually-transmitted Disease
Eating Disorder	Pituitary Disfunction	Stroke	Endometriosis
Mood Swings	Hyperthyriod	Heart Attack	Miscarriage(s)
Substance Abuse	Hypothyroid	Hypertension	Abortion(s)
Auto-Immune	**Nerulogical**	**Respiratory**	**Digestion**
AIDS / HIV	Arthritis	Bronchitis	Constipation
Allergies	Back Pain	Emphysema	Diabetes
Cancer	Carpal Tunnel	Pneumonia	Diarhhia (ongoing)
Fatigue	Dizziness	Tuberculosis	Hepatitis
Fever	Epilepsy		Hypoglycemia
Fibromyalgia	Gout	**Urinary**	Jaundice
Fungal Infections	Insomnia	Bladder Infections	Ulcer
Lyme Disease	Migraines	Kidney Stones	Liver Disorder
Mononucleosis	Musuloskeletal		
	Skin Disorder	**Ears, Nose, Throat**	**Other Issues (list)**
		Earache	
		Jaw Pain	

CLIENT INTAKE FORM – STRICTLY CONFIDENTIAL

Injuries
List any injuries you have had or currently have:

Surguries
List any surgeries you have had or know you will be having:

Trauma
List any traumatic or life threatening events that have occured in your life and when they happened:

Expectations
What expecations do you have fort his healing work – Immediaely and long term:

Other
Anything else you wish to mention?

Present issue of greatest concern

Consent to treatment:
I hereby authorize the CranioSacral Therapist to administer treatments, as she deems necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from treatment.

Signature _____ Date _____