Marklan Linnemeyer, LMT

Cranio Sacral Threrapy

Confidential Client Information

Name:_____ Date:_____

Address:_____ State:_____ Zip:_____

Phone: (H)_____ (C)_____ Date of Birth:_____ Age:_____

Email:_____ Occupation:_____

If a Minor, Parent or Guardian:_____

Referred By:_____

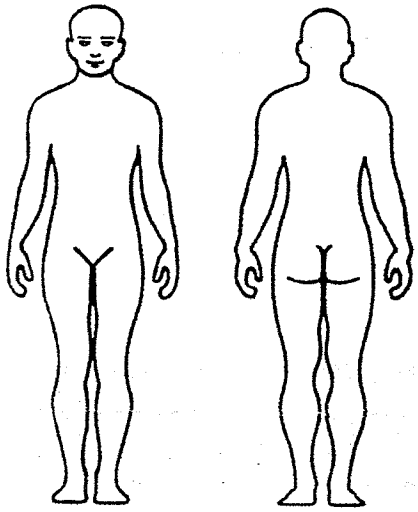
Have you experienced CranioSacral Therapy or another form of gentle Osteopathic manual treatment before? Yes No

On the body outline to the right,
please indicate areas of;

Pain XXXXXXX

Numbness OOOOOO

Tingling //////////



What is your primary reason for todays appointment?_____

_____

Pain or problem started when? _____

_____

On a scale of 1 to 10, with 1 being lowest and 10 being highest, what is the level of pain in your body? 0 1 2 3 4 5 6 7 8 9 10

PLEASE CIRCLE FOR EACH OF THE FOLLOWING:

		PLEASE COMMENT
HIGH BLOOD PRESSURE?	Y N	_____
ANY PROLAPSED ORGANS?	Y N	_____
HISTORY OF AUTO ACCIDENTS?	Y N	_____
OTHER TRAUMAS?	Y N	_____
HAVE YOU WORN BRACES?	Y N	_____
DO YOU EXPERIENCE ANXIETY?	Y N	_____
DO YOU EXPERIENCE DEPRESSION?	Y N	_____
IS YOUR DIGESTION EASY?	Y N	_____
IS YOUR SLEEP RESTFUL?	Y N	_____
TAKING ANTI-INFLAMMATORY MEDS?	Y N	_____
TAKING STATIN DRUGS?	Y N	_____
DO YOU FEEL THAT YOUR BODY MOVES FLUIDLY AND EASILY?	Y N	_____
DO YOU FEEL THAT YOU PROCESS EMOTION EASILY?	Y N	_____

PLEASE LIST ANY PAST INJURIES OR ILLNESSES WHICH YOU FEEL ARE STILL AFFECTING YOUR PHYSICAL CONDITION _____

_____

PLEASE LIST ALL SURGERIES_____

_____

IF YOU HAD NO PAIN, WHAT WOULD YOU LOVE TO DO TODAY?_____

_____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN OR HEALTH CARE PROVIDER? YES NO

PHYSICIANS NAME:_____TITLE/SPECIALTY:_____

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM MY THERAPIST OF ANY CHANGES TO THE ABOVE INFORMATION. I UNDERSTAND THAT THE WORK PROVIDED IS FOR THE PURPOSE OF RELAXATION AND RELIEVING PHYSICAL TENSIONAL PATTERNS. IF I EXPERIENCE ANY DISCOMFORT DURING THE SESSION, I IMMEDIATELY INFORM THE THERAPIST SO THAT THE TREATMENT APPROACH MAY BE ADJUSTED. I FURTHER UNDERSTAND THAT THE WORK PROVIDED IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATION, DIAGNOSIS, OR TREATMENT. I UNDERSTAND THAT THE THERAPIST IS NOT QUALIFIED TO DIAGNOSE, PRESCRIBE, OR TREAT ANY PHYSICAL OR MENTAL ILLNESS, AND THAT NOTHING SAID IN THE COURSE OF THE SESSION GIVEN SHOULD BE CONSTRUED AS SUCH.

SIGNATURE_____DATE_____

Marklan Linnemeyer, LMT
Heart Centered Manual Therapy

MISSED APPOINTMENT AGREEMENT

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation.

We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your health and keeping your scheduled appointments allows us to be partners in your care.

It is our policy that with less than forty-eight hours notice on a change of commitment, a charge may be applied to your account. If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

Client Signature_____

Date_____