CST CLIENT CONSULTATION FORM

Date: ....**Name:** ....
D/O/B: .... **Age:** ....
Address: ....
....
Cell Phone: ....
Number of children: ....**Ages:** ....
Profession: ....
Lifestyle (**Active/Sedentary**)**:** ……………………………………………………….
Last visit to doctor(s): ....
Medications: Prescribed/Dosage/When: ....
....

....
Operations: ....

....
Hospital Admissions: ....
Falls/Accidents: ....
Traffic Accidents: …………………………...
Over-the-counter Medications/Vitamins/Health Products: ....
....

....

Antibiotics/Medication (Dosage/Length): ....
Patients' Comments: ....

....

....

HEALTH/WELL-BEING/DEVELOPMENTAL HISTORY/STATUS

Autonomic System

- Allergies: ....
- Asthma: ....
- Hay Fever: ....
- Eczema: ....
- Dermatitis: ....
- Foods: ....
- IBS: .... Bloating: .... Other allergies: ....
- Hot/Cold Sensitivity (Extremities): ....
- Hyper-Mobility: ....
- Vivid Dreams: ....
- Mood Changeability: ....
- Migraines (Type/Severity): ....

- Headaches (Type/Severity): ....
- Menstrual Issues (Irregularity, Pain, Mood): ....
- Dyslexia, Dyspraxia, ADHD, Autism Spectrum Disorders: ....

Biological Processes / Developmental History

- Delivery: Vaginal / Breech / Caesarean
- Hospital Treatment Required: ....
- Developmental Delay (Milestones): ....
- Educational Support: ....

Musculoskeletal System

- Back Pain: ....
- Sciatica: ....
- Stiff Joints: ....
- Range of Movement Issues: ....
- Arthritis: ....
- Rheumatism: ....
- Osteoporosis: ....
- Fractures: ....

Cardiovascular System

- Blood Pressure: High / Low / Normal
- Heart Issues: ....
- Aneurysm: ....
- Chest Pains: ....
- Thrombosis: ....
- Fluid Retention: ....
- Anemia: ....
- Varicose Veins: ....

Digestive System

- Indigestion: ....
- Hiatus Hernia: ....
- Dyspepsia: ....
- Cirrhosis: ....
- Jaundice: ....
- Liver/Gall Bladder Issues: ....
- Flatulence: ....
- Constipation: ....
- Diarrhea: ....
- Diabetes: ....

Genito/Urinary System

- Kidney Issues: ....
- Urinary Tract Infections: ....

Endocrine / Gynecological System

- Thyroid Issues: ....
- Pituitary Issues: ....
- HRT: ....
- Menopause: ....
- PMT: ....
- Coil: ....

Respiratory System

- Breathlessness: ....
- COPD: ....
- Bronchitis: ....
- Emphysema: ....
- Asthma: ....
- Catarrh: ....
- Sinusitis: ....
- Regular Colds: ....

E.N.T. (Ear, Nose & Throat)

- Ear Infections: ....
- Perforated Ear: ....
- Wax Buildup: ....
- Tinnitus: ....
- Labyrinthitis: ....
- Eye Conditions: ....

Nervous System

- Vertigo: ....
- Sleep Pattern Issues: ....
- Nervous Tummy: ....
- Cognitive Issues: ....
- Obsessive Traits: ....
- Anxiety: ....
- Depression: ....
- Stress: ....

Skin

- Skin Type: Dry / Oily / Combination / Sensitive / Dehydrated / Normal
- Conditions: Dermatitis / Acne / Psoriasis / Skin Cancer / Eczema / Other: ....
- Do you see natural daylight in your workplace? Yes / No
- Do you work at a computer? Yes / No
- Do you eat regular meals? Yes / No
- Do you eat in a hurry? Yes / No

Dietary Habits

- Daily Intake:
  - Fresh Fruit: ....
  - Fresh Vegetables: ....
  - Protein Source: ....
  - Dairy Products: ....
  - Sweet Things: ....
  - Added Salt: ....
  - Added Sugar: ....
- Daily Beverage Intake:
  - Tea: ....
  - Coffee: ....
  - Fruit Juice: ....
  - Water: ....
  - Soft Drinks: ....
  - Other: ....
- Food Allergies: ....
- Smoking: Yes / No (How many per day? ....
- Alcohol: Yes / No (How many units per day? ....
- Exercise: None / Occasional / Irregular / Regular (Types: ....

Other Treatments Being Received

....
....

Any Undiagnosed Conditions?

....

....

CONSENT FORM

I, ..., hereby consent to receive treatment from Pinal Patel at Massage Ponte Vedra. I understand that this treatment is hands-on therapy, and no specific outcomes are guaranteed. The information I have provided is accurate, and I am free to undertake treatment.

Client/Guardian Signature: ....**Date:** ....

CranioSacral Therapist
Signature: ....**Date:** ....
Pinal Patel, LMT/MA104714/CST-T