Amanda Tracy, ND Advanced Health & Wellness (978) 475-7676

CRANIOSACRAL INTAKE FORM

Name: _____

Emergency Contact Name: _____

Emergency Contact Phone:_____

MEDICATIONS List all prescription and over the counter medications you are taking:

Medication	Dose	Date started (year)	Reason/Condition	Does it help?

VITAMINS/SUPPLEMENTS/HERBS Please list all vitamins, herbs and other supplements you are currently taking including the brand names of the items, also **bring the bottles to your first appointment**.

Vitamin/Supplement	Dose (mg/IU, etc.)	Date Started (year)	Reason/Condition

ALLERGIES Please list all of your known allergies:

Medications	
Foods	
Environmental/Other (dust, pollen, cats, chemicals)	

SURGERY HISTORY

Type of Surgery	Year it was Performed

FAMILY HISTORY

Health Condition	Family Member(s)	Health Condition	Family Member(s)
Heart Disease		Breast Cancer	
Diabetes		Colon Cancer	
Stroke		Prostate Cancer	
Autoimmune Disease		Allergies	

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YOUR CURRENT HEALTH

What are the primary health concerns you would like to address with Craniosacral Therapy?

1.
2.

Has anything recently changed or become worse?

Are you currently using any other therapies? (Chiropractic, Acupuncture, Massage, etc.)?

Alcohol (how much/how often)?

Smoking (how much/how often)?

Caffeinated drinks (coffee, tea, soda a day (in cups or ounces)?

How much water do you drink daily (in cups or ounces)?

Exercise (what type/ how often)?

How many hours do you sleep per night?

Do you wake rested?

How many hours do you work each day?

Occupation:

How many hours of relaxation/play do you have each week?

What are your hobbies?

What is your current stress level? (check the appropriate box)
☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

What are the main sources of your stress? (check appropriate boxes)
☐ Job ☐ Family ☐ Health ☐ Finances ☐ Other, please specify

What do you do to reduce/manage/deal with stress?

Select the symptoms that apply to you by checking in the appropriate boxes:

	Past	Present
Fatigue	☐	☐
Trouble Sleeping	☐	☐
Night Sweats	☐	☐
Tension headaches	☐	☐
Migraine Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Mood Swings	☐	☐
Ear Infections	☐	☐
Frequent Cold/Flu	☐	☐
Postnasal drip	☐	☐
Sinus Congestion	☐	☐
Sinus Infections	☐	☐
Heart Palpitations	☐	☐
High Blood Pressure	☐	☐
Heartburn	☐	☐
Nausea or Vomiting	☐	☐
Belching or Passing Gas	☐	☐
Stomach Pain	☐	☐
Indigestion	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Arthritis	☐	☐
Muscle Spasms/Cramps	☐	☐
Thyroid Problems	☐	☐
Diabetes	☐	☐
Low Blood Sugar	☐	☐
FOR WOMEN ONLY	**Past**	**Present**
Menopause	☐	☐
Irregular Cycles/Missed Periods	☐	☐
Painful Periods	☐	☐
Heavy Periods	☐	☐
PMS	☐	☐

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Consent to Treatment

The following may be used to address your health concerns:

Dietary Advice and Therapeutic Nutrition Additions, subtractions or modifications to the diet may be recommended
Lifestyle Counseling and Exercise Recommendations

Potential benefits: Restoration of health and wellbeing, relief of pain and symptoms of disease, improved energy and mental function.
Potential Risks: Allergic reactions to prescribed herbs or supplements and aggravation of pre-existing symptoms.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant because some therapies used could present a risk to the pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Amanda D. Tracy, ND.

Privacy Practices
According to the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to notify you of our Privacy Practices and supply you with a copy of these practices. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosures to other third parties that are involved in your health care elsewhere. We may use your protected health information in order to support various business activities of our clinic. For example, we may call you by name in the waiting room when ready to see you, and we may use your protected health information, to contact you by mail, email or phone to remind you of your upcoming appointments.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Financial Policy
Naturopathic medical care is not covered by insurance companies in Massachusetts. I understand that I am financially responsible for the charges I incur while under the care of Amanda D. Tracy, ND including office visits, phone and email consults and supplements. I understand full payment is required at the time of service or purchase and can be made by personal check, cash, debit card, Visa, MC, AMEX, or Discover cards.

Reservation Fee
Upon scheduling your first appointment, we will collect a reservation fee as a measure of good faith. The fee will be $50.00 and is entirely refundable if you decide not to keep your appointment (provided you cancel or reschedule at least 24 hours prior to your appointment time) and is applied 100% towards your initial consultation; it is not an additional fee.

60 minute Craniosacral Session (teens and adults)…$75

4 Session Pass (teens and adults)…….$250
6 Session Pass (pediatric)……...$225

Cancellations
Because we reserve your appointment time especially for you, a 24-hour cancellation notice is required. A charge of $25 will apply to all non-emergency cancellations with less than 24-hours notice.

Patient's Signature & Date _____