Osiana Wellness
Craniosacral Therapy – Theta Healing
Client Information Form

Please complete this required form before your session as thoroughly as possible.
Confidentiality: All information on this questionnaire will be kept strictly confidential.

Name: ____ E-mail ________________________
Address: _______________________________________ City/Town ____________________
Prov. ________ Postal Code _______________
Phone (best way to reach you): _______________ (☐ cell ☐ home ☐ work – check which one)
Age: _____ Birth Date: _______________________
Occupation/Retired/Student/Other: ____
Emergency contact person: ___________________________________Phone: _____________
Have you had Craniosacral Therapy before? ☐ Yes ☐ No When: _________________________
Have you had ThetaHealing before? ☐ Yes ☐ No When: ______________________________
How did you find out about Osiana Wellness? (if referred, please note the name of the person):
____
Would you like to receive a monthly e-newsletter on specials, events or updates? ☐ Yes ☐ No

Are you currently under a physician's care for any condition? ☐ Yes ☐ No If so, please describe:
____
Are you receiving any other complementary care currently (chiropractor, naturopathic, acupuncture, massage, nutritional, homeopathic, osteopathy, other)? ☐ Yes ☐ No
If so, please describe: ____
____

Primary reason for your visit, (please explain):_____________________________________
____
Main area of complaint - pain, tension, digestive, emotional, mental, etc. (please explain):
____
____
In a few words, please describe your goal for this session: ______________________________
____
Have you suffered any form of trauma your body may be holding? (death, accidents, abuse, etc)
____
____
Are you aware of any trauma along your family lines? __________________________________
____
____

Lifestyle Information

Please rate the following on a scale of 1 (healthy) to 5 (troublesome):

Nutrition ________ Work life ________ Work/life balance ________

Digestion ________ Family life ________ Emotional health ________

Sleep ________ Relationships ________ Mental health ________

Please rate how often you use the following on a scale of 1 (never) to 5 (daily):

Tobacco/Nicotine _______ Alcohol _______ Drugs _______ Caffeine _______ Sugar _______

What tools, practices and activities do you use to relieve stress and maintain your wellbeing?

____

Please check and describe only the ones that apply to you:

☐ Wear contact lenses ☐ Wear dentures

☐ Have had extensive dental work (i.e. braces, etc.)

☐ Car accident (at any time), serious falls or injuries:__________________________________

____

☐ Allergies/sensitivities – Please describe allergens:__________________________________

____

☐ Arthritis - What type and where:____

☐ Heart problem - Please describe: ____

____

☐ Spinal problems – Please describe: ____

____

☐ Presently pregnant - How far along? Complications? _________________________________

____

☐ Have had surgery - When? Complications? ____

____

☐ Taking prescribed medications - Please list: ____

____

☐ Exercise or play sports on a regular basis - Please describe: ___________________________

____

☐ Any other physical, mental or emotional conditions of which I should be aware before giving you a session. Please describe: ____

____

NOTE: *Craniosacral Therapy is considered to be a contraindication for recent fractures to the base of the skull and neck. Please notify Osiana Wellness if you recently experienced this or any other injuries.