Patient Information Form

Gill Redden CRANIO

Last Name: _____
First Name: _____
Marital Status: _____
Gender: M / F
Date of birth: _____
Name of Spouse/Guardian: _____
Children / Age: _____
Home Phone: _____
Mobile: _____
Work Phone: _____
Email: _____
Are you happy to receive my monthly newsletters with tips? Y / N
Home Address: _____
_____
Suburb: _____
City: _____
Post Code: _____
Occupation: _____
Employer Name: _____
Employer Address: _____
_____
What fitness do you do? _____
_____

Complimentary Health: _____
Regular GP: _____
Medical Practice: _____
Dentist: _____
Medical History: _____
(Operations / Accidents) _____
_____
_____
Dental History: _____
_____
Medication: _____
_____
Allergies / Intolerances: _____
_____
Supplements: _____
_____
Do you drink alcohol? _____
Do you smoke? _____
_____
Meals - Breakfast: _____
Lunch: _____
Dinner: _____
Fluid intake: _____

General Information

General:
___ High / low blood pressure
___ Osteoporosis
___ Seizures / convulsions
___ Arthritis
___ Dyslexia
___ Boils, sprains/strains, ulcers
___ Bladder infections
___ Emotional issues
___ Colic / Reflux
___ Prostate problems
___ Bowels too loose / too constipated

Head:
___ Double vision
___ Ear ache
___ Ear infection
___ Tinnitus
___ Headaches
___ Migraines
___ Loss of memory

Neck:
___ Pain with movement
___ Stiff neck
___ Grinding sounds
___ History of neck pain
___ Thyroid
___ Grinding teeth
___ Clicking / Popping
___ Facial restrictions

Shoulders:
___ Can't raise arms
___ Other

Females:
___ Pregnant _____ # months
___ Menstrual pains
___ Irregular cycles
___ Hysterectomy
___ Ovarian cysts
___ Infertility
___ Vaginal infections

Hips, Legs and Feet:
___ Leg cramps
___ Feet feel cold
___ Swollen ankles
___ History of blood clots

Back:
Where: _____
When: _____

Arms and Hands:
___ Hands cold
___ Shooting pains
___ Numbness
___ Tingling
___ Circulation

Other health conditions:
_____
_____
_____
_____

Primary Concern: _____

_____

_____

P.T.O.

Gill Redden
CRANIO

Family Medical History

___ Cardiovascular ___ Arthritis ___ Obesity ___ Alcoholism
___ Diabetes ___ Cancer ___ Mental Illness ___ Stroke

CranioSacral Therapy / Reflexology

Have you experienced CST/R before? Y / N

How was your experience? _____

_____

_____

_____

How did you hear about Gill Redden Cranio?

___ Previous Patient ___ Signage ___ Specialist ___ Doctor

___ Internet - What words did you put in? _____

___ Other - Please specify: _____

Why did you choose us?

___ Reputation ___ Location ___ Opening Hours ___ Advertising
___ First place I called ___ Testimonials ___ Able to get appointment
___ Other - Please specify: _____

Life happens! Kids get sick, the dogs needs to go to the vet, it's the only time you can get to the dentist, you are feeling under the weather, you just forgot to come...
If I have to put time aside for you and you don't come, I still charge you!

Please note that 24 hours notice
of cancellation must be given to avoid full treatment charge.

Signature: _____

Gill Redden CRANIO

Patient Treatment Plan

- Every patient needs a set of Treatment Goals that are used to monitor your progress
- Treatment Goals are based around normal daily functions that you do
- Once your Treatment Goals have been achieved, your treatment stops, however regular maintenance is recommended to keep you in peak condition
- From time to time the Treatment Goals may need to be adjusted to accommodate new information that comes to light over the course of your treatment

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Write some specific goals that you can personally use to measure your progress or specific things that you currently cannot do as a result of your health problem

0 is bad, 10 is excellent

Specific Activity	Please indicate how you feel at this moment doing this particular activity										
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10