Wyldwood Sanctuary
CONFIDENTIAL HEALTH HISTORY FORM

Date:_____

Name: _____email:_____

Address:_____

City/State: _____Phone Number:(h) _____ (c)_____

Occupation: _____ Birth Date: _____

Emergency contact:_____ Phone: _____

Reason for today's visit: _____

Have you seen a physician for this issue? ☐N/A ☐ Yes ☐No What was their recommendation?_____

Are you currently under physician's care? ☐Yes ☐No for: _____

MEDICAL HISTORY: (**check** all that currently apply. Mark previous conditions with a **P**)

☐ Asthma	☐ Disk problems: herniated, bulging, degenerative, broken, fused	☐ Infection (current)	☐ PTSD
☐ Anxiety /stress	☐ Difficulty breathing/chest pain	☐ Injuries (list below)	☐Sprains/strains/tendonitis
☐ Arthritis: RA Osteo	☐ Dizziness/vertigo	☐ Joint pain/swelling/replacement	☐ Skin disorder/rash
☐ Allergies	☐ Diabetes	☐ Lymphedema/edema	☐ Staph/MRSA (past or present)
☐ Autoimmune Disorder	☐ Digestive condition/disorder	☐ Musculoskeletal disorders	☐ Stroke, TIA
☐ Blood clots/disorders	☐ Fibromyalgia/chronic fatigue	☐ Menopause/hormone imbalance	☐ Seizures
☐ Cancer	☐ High blood pressure	☐ Multiple sclerosis	☐ Sinus problems
☐ Chiari Malformation type:_____	☐ Heart condition/previous heart attack	☐ Numbness/tingling Neuropathy	☐ Sleeping problems: apnea/insomnia
☐ Chronic pain	☐ Hearing: impaired, tinnitus, hearing aid	☐ Neck/back/spine problem or pain	☐ Trauma Physical or Emotional
☐ Circulatory condition	☐ Hepatitis type:_____	☐ Osteoporosis/ osteopenia	☐ Thyroid/endocrine disorders
☐ Concussion	☐ HIV/Aids	☐ Parkinson's	☐ TMJ disorder
☐ Covid-19 / w/complications	☐ Headaches: migraine, non-migraine	☐ Pregnancy/C-section, Abdominal surgery	☐ Whiplash
☐ Depression	☐ Herpes/shingles	☐ POTS	☐ Other (List below)

Other: _____

Have you had a Covid-19 vaccine? ☐Yes ☐No If yes, when? _____

Have you had a Covid booster shot? ? ☐Yes ☐No If yes, when? _____

Recent accidents/surgeries: ☐N/A _____

_____

_____

Previous accidents/surgeries: ☐N/A _____

_____

Current medications: ☐N/A _____

What is the level of **stress** in your life? (low- high) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Current stress reduction activities:_____

What is your current **pain** level? (low- high) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Pain duration: ☐New ☐1-3 months ☐3-6 months ☐chronic 6+months _____

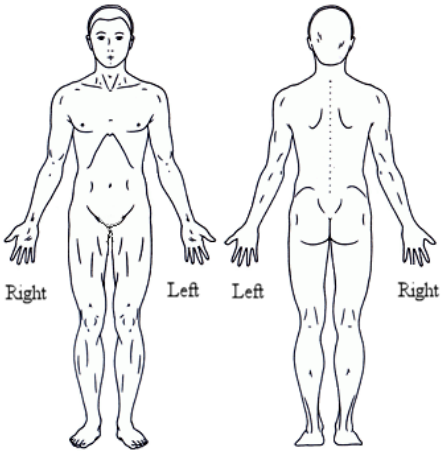
Does pain/stiffness/tension limit daily activities? ☐Yes ☐No

Do you have any joint pain, restrictions or loss of mobility? ☐Yes ☐No If yes, where? _____

Have you tried other complementary therapies? ☐Yes ☐No

Did you experience any uncomfortable or adverse reactions to any of these therapies? ☐Yes ☐No

Please **circle** areas of concern:



Mark areas of:

Pain with **P**'s

Tenderness with **T**'s

Numbness/tingling with **Z**'s

Swelling/stiffness with **S**'s

Do you have any other concerns? ☐Yes ☐No _____

I understand that craniosacral and restorative mind-bodywork therapies should not be construed as a substitute for medical examination, diagnosis, or treatment. Because craniosacral and restorative mind-bodywork should not be performed under certain circumstances, **I affirm that I have stated all medical conditions of which I am aware. And I agree to inform my practitioner of any changes in my health and medical status and understand that there shall be no liability on the practitioner's part should I fail to do so.**

I have read and understand Wyldwood Sanctuary's appointment cancellation and payment policies **?** ☐Yes

Signature: _____ Date: _____ rev 10/2021

All client information shall be held in strictest confidence except where required by law.