Heidi Wrenn Winter LMT

Cranial Sacral Therapist
541-603-8482
1034 Lawrence St.
Eugene, Oregon 97401
activelife-health.com

For Office Use

First Contact:_____

Patient Preferred Name:_____

Preferred Method Contact: _____

Name:_____Date: _____

Phone Number:_____Email Address: _____

Occupation:_____Work Phone Number: _____

Mailing Address:_____City:_____State:_____Zip: _____

Emergency Contact (name, phone number, relationship): _____

Date of Birth:_____ Referred by: _____

General & Medical Information

Please circle:

Yes No Have you ever had professional bodywork? If yes, please list type in comment area of this form.

Yes No Are you currently under a physician's care or any other health practitioner's care? If yes, Please explain in the comments area of this form.
If yes, please name physician or health practitioner:

_____

Yes No Do you have tension in a specific area?

_____

Yes No Do you have numbness or stabbing pain anywhere?

Yes No Are you acutely sensitive to touch/pressure in any area?

Yes No Have you had any accidents resulting in acute injury, and/or disability? (i.e. broken bone, concussion, acute contusion)

Yes No Have you been hospitalized and/or had surgery (including major dental)? If yes, please explain in the comments area of this form.

Yes No Are you diabetic? Type I or II? If yes, please circle which one.

Yes No Have you been or currently being treated for cancer?

Yes No Do you have an auto-immune disease?

Explain: _____

_____

_____

Yes No Do you have high or low blood pressure?
If yes, please circle which one.

Yes No Do you experience frequent headaches/migraines?

Yes No Do you experience debilitating stress, anxiety or depression?

Yes No Do you have cardiac, circulatory or kidney issues?

Yes No Are you effected by seizure disorders or epilepsy?

Yes No Do you have allergies?
If yes, please explain in the comments area of this form.

Yes No Are you taking prescription medication, herbs, or nutritional supplements (including naturopathic, homeopathic, oriental, ayurvedic, etc.) for any of these or any other condition?
If yes, please list in the comment area of this form.

Yes No Are you wearing contacts?

Yes No Are you pregnant?

Yes No Are you peri-menopausal or menopausal?

Yes No Do you participate in an activity/exercise program?
If yes, please explain in the comment area of this form.

Yes No Do you have any other medical condition or health information you would like to share?
If yes, please explain:

_____

_____

Comments: _____

_____

What is your primary complaint? Please list in order of importance to you._____

_____

_____

Please take a moment to carefully read the following information and sign where indicated.

Notice Of Privacy Practices

I am committed to preserving the privacy of your personal health information. Providers are required by law to protect the privacy of your medical information and to provide you with notice to inform you of:

How medical information about you may be used and disclosed and how you can access this information.

I am required by law to have your written consent before I use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

I may be required or permitted by certain laws to use and disclose your medical for other purposes without your consent or authorization.

As my patient, you have important rights relating to inspecting and copying your medical information that I maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that I restrict certain uses and disclosures of your health information, and complaining if you think you rights have been violated.

I have available a detailed Notice Of Privacy Practices available for you to read, which fully explains your rights and our obligations under the law.
I may revise the notice from time to time.

You have the right to receive a copy of our most current notice in effect. If you have not yet read a copy of our current notice, please ask me and I will provide you with a copy.

If you have any questions about this notice or your medical information, please contact me at 541-603-8482.

I authorize the release of any medical or other information necessary to aid in communication between healthcare professionals on my behalf.

Information And Suggestions For The Client

I understand that the bodywork I receive is provided for the basic purpose of the promotion of whole health and consent to this. If I experience any pain or discomfort during this session, I will immediately inform the therapist. I further understand that the bodywork session should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a qualified medical specialist for any physical or mental ailment that I am aware of. I understand that Licensed Massage Therapists are not qualified to diagnose or prescribe treatment of any physical or mental illness and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my profile and understand that there shall be no liability on the therapists part should I neglect to do so. It also my responsibility to inform the therapist if I am under the influence of any substance that may effect the safety of the treatment I am receiving, or injure/alter another practitioner's treatment. I agree to provide a 24-hour cancellation notice.
If I fail to do so I agree to pay half of the appointment fee.

Please let me know what I can do to promote your comfort and feel free to ask me any questions about the procedures I use. I am more than happy to help you feel well informed.

Before you arrive:

Please plan for a full hour as this allows for the treatment and the necessary time of communication before and after.

Avoid caffeine. Caffeine being a stimulate will keep your adrenals activated and the mind unsettled.

Drink an extra glass of water 30 minutes before your session. Water aids in the communication between cells, enriching your healing experience.

After your session:

Please allow for integration time following your appointment. This time will help retain the relaxed state where healing occurs. A short walk afterwards is an excellent way to integrate.

Drink several more glasses of water than what you usually would drink during a day. Water creates flow and cleanses the system—drink up!

Signature:_____ Date:_____