THE WELLNESS STUDIO
FAMILY CHIROPRACTIC & WELLNESS CARE

CST Adult Intake Form

Name:_____ Date:_____

Address: _____ Postal Code: _____

Email Address: _____

Phone: (H)_____ (W) _____ (C) _____

Emergency Contact: _____

Birthdate: _____ Age: _____ Height/Weight: _____

Occupation: _____

Were you referred to this office? (Y/N) By Whom? _____

Is this visit a result of a Work Related or Motor Vehicle Accident?: _____

What is the reason for your visit?: _____

Have you had any previous treatment for this condition?: _____

What makes it better? _____ What makes it worse? _____

What other types of treatments are you currently receiving? (Chiropractic, Massage, Acupuncture, etc.)

_____

_____

Are you seeing any specialists?_____

What medications are you currently taking?_____

_____

Please list any major surgeries, injuries, or illness that you have experienced and when they occurred:

_____

_____

_____

Please circle any of the following that concern or pertain to you:

Pregnancy ○	Cancer ○	Fainting ○	Epilepsy ○
Concerns about fertility ○	Diabetes ○	Dizziness ○	Epidural/spinal Anesthesia ○
Miscarriage ○	High Blood Pressure ○	Sensitivity to light and/or sound ○	Meningitis (or suspected) ○
Labour/Delivery Trauma ○	Varicose Veins ○	Pins and Needles ○	Concussion ○
Fibromyalgia ○	Heart Condition ○	Facial Pain or swelling ○	Brain/Head Injury ○
Anxiety ○	Tooth, or mouth pain ○	Jaw Pain ○	Coordination problems ○
Sinus Problems ○	Allergies ○	Back Pain ○	Concentration Problems ○
Fractures/ joint replacements ○	Skin Condition ○	Headaches and/or Migraines ○	History of Learning challenges ○

Is there anything else you would like us to know?:

_____

_____

_____

I understand that Massage Therapy and/or CranioSacral therapy are aids to health and it is my choice to receive treatment. I agree to communicate with my therapist any time I feel my well-being is compromised. I understand that Massage Therapy and/or CranioSacral Therapy are not substitutes for medical examinations or diagnosis and that it is recommended that I see a primary health care provider for that service. I have disclosed all existing medical conditions I am aware of and understand that it is my responsibility to update my therapist of any changes to my health status.

I also understand that the treatment fee will be charged for missed appointments unless 24 hours notice is given.

Date: _____

Client Name (Please Print): _____

Client's or Guardian's Signature: _____

Witness of Signature: _____