TRUDY TYLER BARNES, L.M.T.

(Cranial Sacral Therapy, Emotional Clearing Therapy)

Name:		
Street Address:	City:	State & Zip Code:
Home Phone:	Cell Phone:	E-Mail:
Date of Birth:	Gender:	
Occupation:		
Referred by:		
Physician:	Phone:	

Please list the ***purpose for any medications*** you are currently taking:

Do you now have, or have you ever had any of the following:

Seizures?	❑ Yes	❑ No	Stroke, Heart Attack?	❑ Yes	❑ No
Allergies to oils?	❑ Yes	❑ No	Pacemaker?	❑ Yes	❑ No
Allergies to medications?	❑ Yes	❑ No	Breast Augmentation?	❑ Yes	❑ No
Nervous tension?	❑ Yes	❑ No	HIV?	❑ Yes	❑ No
Abdominal pain?	❑ Yes	❑ No	Hepatitis?	❑ Yes	❑ No
Diabetes?	❑ Yes	❑ No	Varicose Veins?	❑ Yes	❑ No
Arthritis, bursitis, gout?	❑ Yes	❑ No	High Blood Pressure?	❑ Yes	❑ No
Contacts or Prosthesis?	❑ Yes	❑ No	Surgery?	❑ Yes	❑ No
Broken Bones?	❑ Yes	❑ No	Whiplash?	❑ Yes	❑ No

Do you have a History of any of the following:

Accidental Injury?	❑ Yes	❑ No	Low Back Pain?	❑ Yes	❑ No
Neck/Shoulder Problems?	❑ Yes	❑ No	Joint Ache?	❑ Yes	❑ No
Headaches?	❑ Yes	❑ No	Sprains?	❑ Yes	❑ No
Disk Problems?	❑ Yes	❑ No	Decreased Range of motion?	❑ Yes	❑ No
Mid Back Pain?	❑ Yes	❑ No			

Do you use: Caffeine? ❑ Yes ❑ No Tobacco? ❑ Yes ❑ No Alcohol? ❑ Yes ❑ No

Do you drink 8 glasses of water daily? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No

Please list your focus for today's session:

I understand that Trudy Barnes ***cannot diagnose any medical condition or prescribe any medical treatment***. I also understand that the therapist ***cannot accept insurance payments*** and therefore that payment for all services provided by the therapist is due and payable at the time such services are rendered. ***Missed appointments will be charged full price, unless canceled 24 hrs. in advance.***

Date:______________________ Signature: ____