RUBATO Intake Form

Circle: craniosacral or massage

Date:_____

Name _____ Phone _____ Cell Phone _____

Email _____ Address _____

Date of Birth _____ Sex ____ Marital Status ____ Occupation _____

Contact in emergency: _____ Phone _____ Doctor _____

YOUR SYMPTOMS: Please rate from *most* troublesome to *least* troublesome. Use the box to help you --->

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you had (Circle):
Massage Chiropracty Acupuncture
Acupressure Craniosacral Reiki
Reflexology Feldenkrais Rolfing
Trager Thai Massage _____

Symptoms - Please Circle:

pain (sharp, dull, shooting, ache, sore, where)

headaches dizziness balance problems

difficulty reading fatigue tinnitus

depression nervous numbness (where)

tingling (where) fuzzy sight sciatica

concentration difficulties anxiety stress

sinus problems decreased range of motion

sleep difficulties lack of energy other

List medications & their purpose:

_____

List your exercise or activity: _____

Circle any that apply: fibromyalgia diagnosed stroke disc problems fusion recent surgery Lupus whiplash seizures cancer history heart condition rash arthritis bursitis allergies wear contacts scoliosis carpal tunnel syndrome mastectomy fever diabetes varicose veins high blood pressure colitis HIV ADD dyslexia ulcer swelling asthma herpes TMJ cramps heaviness in head thyroid condition tendonitis tennis elbow golf elbow inflammation Chron's disease meditation pregnant open sore cold sores I hold the telephone with my shoulder I sit at least 2 hours daily at a desk or computer

CRANIOSACRAL ONLY: Please list as many falls, car accidents, or blows to the head/spine/tailbone as you can remember, starting with the year, a short description, and subsequent symptoms:

Year:_____

_____

Year:_____

_____

Year:_____

_____

Year:_____

_____

Anything else I should know? _____ *(over)*