ADULT HEALTH HISTORY (13 years and older) Confidential Information Form

Bethany Bachmann LLC

General Information: Today's Date: _____

Name:_____DOB: _____

Address:_____City_____State_____Zip_____

Phone:_____Occupation:_____

Email: _____Referred by:_____

Emergency Contact name: _____Relationship:_____Phone: _____

Are you currently under the care of a Health Care Practitioner? Yes_____ No_____

Primary Health Care Provider name: _____Phone: _____

Are you currently seeing a Mental Health Counselor? Yes_____ No_____

Mental Health Counselor name: _____Phone: _____

Do you smoke? Yes_____ No_____ Caffeine _____ cups/day Weekly alcohol consumed:_____

How is your average stress level?_____Sleep?_____

Stress reduction activities (nature, walking, hobbies etc.):

_____

_____

Please list primary reason for seeking craniosacral therapy:

_____

_____

Have you seen any other health practitioners for this same/similar condition? If yes, please list the type of treatments & if they were beneficial:

_____

_____

Please list all current medications & supplements (including over-the-counter medication, vitamins, herbs etc.):

_____

_____

HEALTH HISTORY: Please check all conditions that apply to you (now or in past).

_____ Allergies (topical/internal)
_____ Anemia
_____ Aneurysm
_____ Anxiety
_____ Appetite or weight changes
_____ ADD/ADHD
_____ Arthritis
_____ Autism
_____ Asthma
_____ Blood clots
_____ Bowel/bladder problems
_____ Blood pressure (high/low)
_____ Cancer/tumors
_____ Cerebral palsy
_____ Circulatory problems
_____ Concussion
_____ COPD (respiratory)
_____ COVID-19
_____ Depression
_____ Dentures
_____ Diabetes
_____ Dislocations
_____ Dizziness/vertigo
_____ Drug/alcohol addiction
_____ Eating disorders
_____ Fatigue
_____ Fibromyalgia
_____ Fractures
_____ Headaches
_____ Head injuries
_____ Heart condition
_____ Hepatitis
_____ Herpes/cold sores
_____ HIV
_____ Hysterectomy
_____ Intestinal/digestive problems
_____ Jaw pain (TMJ)
_____ Kidney problems
_____ Learning disabilities
_____ Memory problems
_____ Migraines
_____ Multiple sclerosis
_____ Neck or back injuries
_____ Orthodontics/major dental work
_____ Osteoporosis
_____ PTSD
_____ Pacemaker
_____ Pregnancy/childbirth
_____ Ringing in ears (tinnitus)
_____ Seizures/epilepsy
_____ Shingles
_____ Sinus problems
_____ Skin problems
_____ Teeth clenching or grinding
_____ Thyroid problem (high/low)
_____ Traumatic brain injury
_____ Visual disturbances
_____ Other

List major injuries and surgeries below (include date):

_____
_____
_____
_____

Anything else you would like me to know about you? (more details on health history, significant family history, car accidents etc.):

_____
_____
_____
_____

Birth History (what do you know about your birth):

_____
_____

FOR WOMEN ONLY: Are you pregnant? Yes_____ No_____ If yes, which trimester? 1st 2nd 3rd