PURA VIDA HEALTHCARE
Your Mind-Body Connection

Intake and Consent Form

DeVere Keen Gamble
Craniosacral Therapist & Holistic Health Coach

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____ Employer: _____

Referred By: _____

Emergency Contact Name/Relationship: _____ Emergency Contact Phone: _____

Physician's Name: _____ Physician's Phone: _____

Reason for visit: _____

Please list any regular exercise and activities you participate in: _____

Please list any major injuries or surgeries (include month and year): _____

_____

Please list any medications you are currently taking: _____

_____

Please circle any of the following conditions that apply to you, currently or in the past:

Musculoskeletal
Bone or Joint Disease
Tendinitis/Bursitis
Arthritis/Gout
Jaw Pain (TMJ)
Lupus
Spinal Problems
Migraines/Headaches
Osteoporosis

Nervous System
Shingles
Numbness/Tingling
Pinched Nerve
Chronic Pain
Paralysis
Multiple Sclerosis
Parkinson's Disease
Autoimmune Issues

Circulatory
Heart Condition
Phlebitis/Varicose Veins
Blood Clots
High/Low Blood Pressure
Lymphedema
Thrombosis/Embolism

Respiratory
Breathing Difficulty/Asthma
Emphysema
Sinus Problems
Allergies, please specify:

_____

Reproductive
Pregnant, # of Months: _____

Skin
Rashes
Cosmetic Surgery
Athlete's Foot
Herpes/Cold Sores
Allergies, please specify:

_____

Digestive
Irritable Bowel Syndrome
Bladder/Kidney Ailment
Colitis
Crohn's Disease
Ulcers

Psychological
Anxiety/Stress Syndrome
Depression
PTSD

Other
Cancer/Tumors
Diabetes
Drug/Alcohol/Tobacco Use
Contact Lenses
Dentures
Hearing Aids
Concussion
TBI

Any other medical condition(s) not listed:

_____

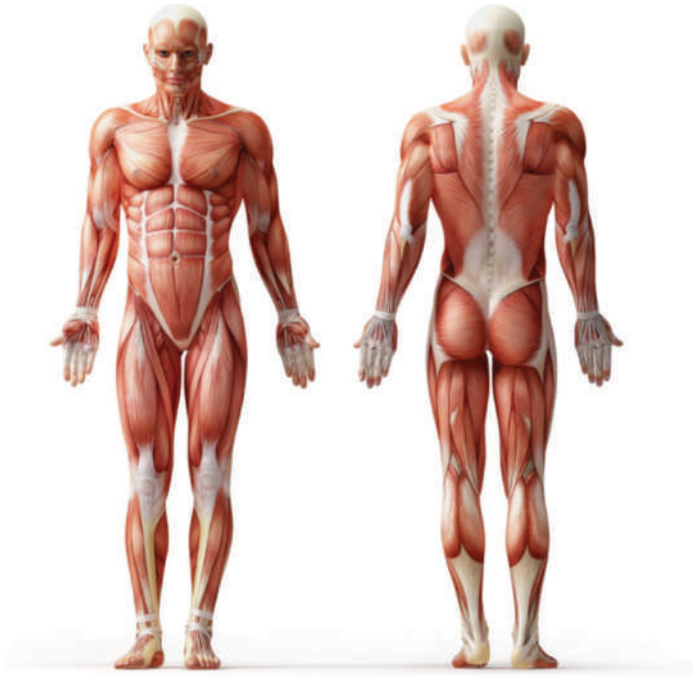
_____

_____

_____

_____

Please mark any body parts where you are experiencing discomfort or pain:



By signing this statement, I acknowledge and understand that the treatment I am about to receive is in the best interest of my needs and wellbeing. I hereby take full responsibility for myself and consent to allowing the therapist to perform her treatment. The cranio-sacral therapist performing the treatment is doing so within her scope of practice. In case she is not able to help me, she will refer me to someone who can better suit my needs.

Signature: _____ Date: _____

Signature of parent or legal guardian (if client is a minor): _____

Cancellation Policy: I understand that it is my responsibility to cancel an appointment 24 hours before its scheduled time or be charged the full amount of my scheduled visit.

Signature: _____ Date: _____