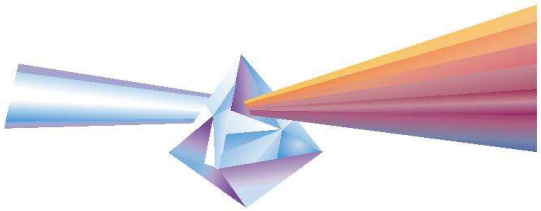

Lightstreams Holistic Health Care PLLC

Dr. Nancy Anne Schrauth DC, RCST®
651.964.9048, dr.nancy.schrauth@gmail.com

Please provide the following information, it will be kept confidential

Full Name _____ pronouns_____

Postal Address _____

Email address _____ Cell Phone _____

Occupation _____ live with partner/friends/family _____ live alone _____

Date of Birth_____ Number/Age children _____

Current condition; please explain why you are here, describe any injury/pain or dysfunction; and how and when it started _____

_____

List any therapy you have had/are having for this condition _____

Other significant health conditions, past and present _____

_____

_____

List any/all medication/drugs you take, what it's for and how long you have been taking it _____

_____

List any recreational drugs you use and how often (including alcohol, tobacco) _____

List any surgery you have had _____

List any significant past injuries, accidents or trauma (physical/mental/emotional) _____

Do you have any other health concerns? _____

Do you have problems with the following? Please explain:

- Digestive system _____
- Sleep _____
- Mental/emotional _____
- Breathing _____
- Memory _____
- Fatigue _____
- Reproductive system _____

Please turn over

What is your current level of stress? None Low Moderate High Severe

What is your primary source of stress? _____

How do you cope with stress? _____

List the type of exercise you do and the frequency; _____

_____

List activities/hobbies you enjoy and participate in regularly: _____

_____

Have you ever received Craniosacral Therapy? Yes No If so, describe your experience?

_____

What are your expectations from this session? _____

List 3 goals or objectives in order of importance you would like to achieve from our work together:

1. _____
2. _____
3. _____

Is there anything else that you think would be helpful? _____

How did you find out about this therapy/clinic? _____

Informed consent

- I have read and understand the Informed Consent form provided by Lightstreams Holistic Health Care PLLC
- I agree to receive emails from Lightstreams Holistic Health Care PLLC about relevant information and schedule updates

Signature/date: _____