Paul Raish, N.D. 215 S. Complex Drive, Kalispell, 59901

Cranial Sacral Therapy Intake Form

Today's date _____

Name _____

Gender: ☐ Female ☐ Male Age _____ DOB _____

Address _____

City/State/Zip _____

Phone: (_____) _____-_____ E-mail:_____

In Case of Emergency,Contact:_____Relationship:_____

Phone: Home: (____) ____ - _____ Work: (____) ____ - _____ Cell: (____) ____-_____

Please tell us how you found out about our office or who you were referred by:

_____

What condition/injury do you have that you are seeking relief for?

_____

How long have you been living with? _____Has it gotten worse overtime? _____

Please rate your pain or discomfort (10 being the highest):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Any ideas/history about the source of this condition?

Are there any emotional issues attached to this condition/injury?

_____

Please email to thenaturalpath@ protonmail.com