the magical ones
Bek Wiltbank, MOTR/L

425-814-2045
425-814-2783 fax

Adult Health Questionnaire

Patient Name:_____ **Date of Birth:**_____

Exercise level: ____ active ____ moderate ____ light ____ no exercise

Nutritional habits: # vegetables per day _____ # fruits per day _____ whole grains _____

WATER:oz. per day_____ supplements _____
Allergies: _____

Birth and Infancy History (What your parents may have told you):

____ Caesarian delivery ____ Forceps or vacuum suction delivery

____ Breast fed ____ Bottle fed ____ Ear inflammations/infections

____Sucked thumb ____Used pacifier ____Teeth Grinding

____ Frequent illnesses ____ Vaccinations: _____

____Falls, after which you lost consciousness

Age you began walking_____ Age you began talking_____

Current health concerns (in order of importance) Date of onset

1.

2.

3.

4.

Have you ever had Craniosacral Therapy?

What do you hope for with treatment:

_____

What factors do you feel are contributing to your current state of health?

_____

Primary Care Physician: Phone number:

_____

Other health care practitioners (i.e. medical specialists, acupuncturist, chiropractor, counselor, other specialists)

_____

Any medical diagnoses: _____

Please list and include dates if possible:

• Surgeries: _____

• Accidents/injuries: _____

• Major Illnesses/Hospitalizations: _____

Current	Past	Description
☐	☐	Headaches: _____
☐	☐	Pain: _____
☐	☐	Sleep Disturbance: _____
☐	☐	Fatigue: _____
☐	☐	Sinusitis: _____
☐	☐	Other: _____

Please mark any of the following conditions you have now or have significant history of in the past.
General

Muscles and Joints

Current	Past		Description
☐	☐	Bone or Joint Disease:	_____
☐	☐	Osteoporosis:	_____
☐	☐	Broken Bones:	_____
☐	☐	Tendonitis/Bursitis:	_____
☐	☐	Arthritis:	_____
☐	☐	Scoliosis:	_____
☐	☐	Disc Problems:	_____
☐	☐	Lupus:	_____
☐	☐	Sprain/Strain:	_____
☐	☐	Jaw Pain/TMJ:	_____
☐	☐	Neck/Shoulder/Arm Pain:	_____
☐	☐	Hip/Low back Pain:	_____
☐	☐	Knee/Ankle Pain:	_____

Nervous System

Current	Past		Description
☐	☐	Head injuries/Concussions:	_____
☐	☐	Dizziness/Ringing in ears:	_____
☐	☐	Numbness/Tingling:	_____
☐	☐	Sciatica/Shooting pains:	_____
☐	☐	Pinched Nerve:	_____
☐	☐	Bell's Palsy:	_____
☐	☐	Other:	_____

Endocrine System

Current	Past		Description
☐	☐	Diabetes:	_____
☐	☐	Thyroid Condition:	_____
☐	☐	Other:	_____

Respiratory/Cardiovascular

Current	Past	Description
☐	☐	Heart Condition: _____
☐	☐	Blood Clots: _____
☐	☐	High/Low Blood Presure:_____
☐	☐	Stroke: _____
☐	☐	Irregular Heart Beat: _____
☐	☐	Poor Circulation: _____
☐	☐	Edema/Swollen Ankles: _____
☐	☐	Chest Pain/Short of Breath: _____
☐	☐	Asthma: _____

Digestive/Elimination System

Current	Past	Description
☐	☐	Constipation/Diarrhea: _____
☐	☐	Gas/Bloating: _____
☐	☐	Irritable Bowel Syndrome:_____
☐	☐	Gastric Ulcers: _____
☐	☐	Bladder/Kidney Dysfunction:_____
☐	☐	Other: _____

Reproductive

Current	Past	Description
☐	☐	Pregnancy: _____
☐	☐	Menstrual problems: _____
☐	☐	Prostate problems: _____
☐	☐	Other: _____

Other

Current	Past	Description
☐	☐	Cancer: _____
☐	☐	Anxiety/Stress: _____
☐	☐	Tobacco Use: _____
☐	☐	Drugs: _____
☐	☐	Alcohol. Drinks/week: _____
☐	☐	Other: _____

I confirm that the above information is true, accurate, and complete, to the best of my knowledge.

Signature_____ Date _____

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Informed Consent for Treatment

I, _____, hereby authorize Bek Wiltbank, MOTR/L to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Occupational Therapy, including craniosacral therapy techniques.

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the therapist if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Bek Wiltbank, MOTR/L regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Bek Wiltbank, MOTR/L to the best of her ability.

_____ _____
Date Signature of Patient

_____
Signature of Patient Representative OR Guardian

I authorize The Magical Ones to send email and/or text reminders for appointment times. I acknowledge that this information is sent over electronic means that are not confidential.

Signature:_____ Date: _____