CranioSacral Therapy 'BASELINE' Questionnaire

Please complete at start of treatment

Patient's date of birth: Male / Female Date first treatment:

Therapist please complete above this line Therapist's name:

---

1. What is the main problem for which you are seeking help?

2. What other current problems do you hope it might help?

3. How long have you had the main problem?

4. What medication, if any, do you take for it?

5. What impact is the main problem having on your life?

   Minimal / Moderate / Major

7. While seeking help for your main problem have you:

   a. seen a hospital specialist? Yes / No

   b. been admitted to hospital? Yes / No

   c. received physiotherapy? Yes / No

   d. received any alternative therapy? Yes / No

8. How many times have you seen your GP in the past year?

   0 1 2-5 6-10 >10 Please circle