Tidesong Healing Arts
Joseph Ulysse Saine, LMT, RCST®

Adult Client Information

Name: _____ DOB(mm/dd/yyyy):_____

Gender Pronoun (Please Circle): She/Her/Hers, He/Him/His, They/Them/Theirs, Other:_____

Address:_____ City/State:_____

Zipcode:_____ Phone:_____(Circle: Home/Work/Cell)

Email:_____ Phone:_____ (Circle: Home/Work/Cell)

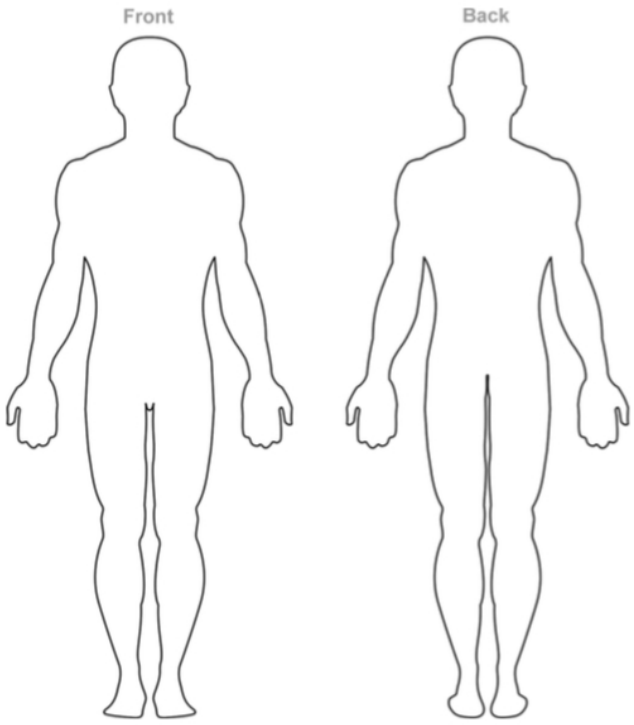
Emergency Contact (Name, Relationship, Phone) :_____

Primary Reason(s) for Visit:_____

Frequency of Symptoms:_____

What makes better or worse?_____

Please mark any areas where you are currently feeling discomfort:



For the following questions 1 = best, 5 = worst:

What is your level of pain? 1 2 3 4 5 What is your level of stress? 1 2 3 4 5

What is your quality of sleep? 1 2 3 4 5 What is your quality of digestion? 1 2 3 4 5

What is your sense of wellbeing?: Physical 1 2 3 4 5 Emotional 1 2 3 4 5

Mental 1 2 3 4 5 Overall 1 2 3 4 5

Have you had bodywork before? What kind(s)?_____

What type of work do you do?_____

Are there activities you do repetitively?_____

Do you exercise/stretch? What kind? How often?_____

Are you currently receiving healthcare? For what condition(s)?: _____

_____

Please specify any medications you are taking: _____

_____

Have you ever been injured or in any accidents? Please explain: _____

_____

Have you ever had surgery? Please explain:_____

Have you experienced Trauma that you would like me to be aware of? Please explain: _____

_____

Are you experiencing any of the following conditions? (check all that apply)

☐ Effects of Trauma (PTSD/CPTSD, etc.)
☐ Nervous System Dysregulation
☐ Behavioral Disorder
☐ Mental Fog/Trouble Focusing/Disassociation
☐ Headaches
☐ Stress/Anxiety
☐ Depression
☐ Grief
☐ Chronic Fatigue
☐ Fibromyalgia
☐ Neuropathy
☐ Jaw Pain (TMJ)
☐ Inflammation
☐ Circulatory/Heart Problems
☐ Heart Attack
☐ Stroke (CVA)
☐ Blood Clots/Varicose Veins
☐ High/Low Blood Pressure
☐ Spinal Condition
☐ Numbness/Tingling
☐ Neurodivergence (Atypical Brain Function)
☐ Breathing Difficulties/Asthma
☐ Digestive Problems
☐ Cancer
☐ Diabetes
☐ Kidney/Liver Disease
☐ Menstrual/Ovarian Difficulties
☐ Pregnancy
☐ Bone or Joint Disease
☐ Arthritis
☐ Chronic Pain

☐ Other Diagnosed Conditions (Please Explain):_____

☐ Other Undiagnosed Symptoms (Please Explain):_____

☐ Allergies:_____

Is there anything else you would like me to know?_____

What is your intention for receiving bodywork?_____

I am aware of the benefits and risks of bodywork and give my consent to receive Manual Therapy, Craniosacral Therapy and Trauma-Informed Somatic Bodywork from Joseph Ulysse Saine LMT, RCST®. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that bodywork is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.
I am responsible for all charges for all services provided. I understand that there is a 24-hour cancellation policy and all missed appointments will be charged for.

Signed_____ Date:_____