



CranioSacral Therapy Worksheet

The information provided helps to monitor your progress. Please complete this questionnaire and bring it to your next visit. You may also fax this form or download it from our website and send it via e-mail.

NAME _____ DATE OF VISIT _____

1. How did you feel immediately after the session? (note pain, releases, relaxation)
2. How did you feel throughout the evening? (any changes after you left the office)
3. How did you feel going to sleep? (were you wired, tired, relaxed, or anxious)
4. How did you sleep? (hard, lightly, better, worse)
5. How did you feel when you woke up? (alert, lethargic, in pain, increased relief, etc.)
6. Other things to note:
 - Areas of relaxation
 - Areas of pain (specific if possible)
 - Areas of restriction
 - Areas of release
 - Any other notable differences compared to how you felt before treatment.

“Three Locations - One Family of Therapists”

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