CranioSacral Therapy Worksheet

Glendy Morrison, LMP

Name: ______________________________ Date of Visit: ____/____/____

1. How did you feel immediately after the session? (note: pain, releases, relaxation)

   ____

2. How did you feel throughout the evenings? (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, or 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 ______________________________
   - Areas of restriction ______________________________
   - Areas of release ______________________________
   - Any other notable differences compared to how you felt before treatment ______________________________

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