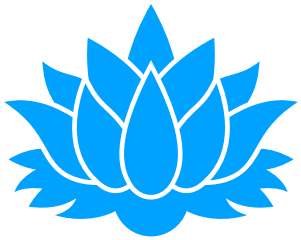

CFT Questionnaire

Have you experienced?

_____ **TBI/Concussions**

_____ **Auto accidents**

_____ **Childhood accidents/injuries**

_____ **Broken bones**

_____ **Sports injuries**

_____ **Whiplash**

_____ **Falls**

_____ **Dental Work/Surgeries**

_____ **Orthodontics**

_____ **Surgeries**

_____ **Injections**

_____ **A Difficult Birth**

_____ **Childbirth**

- **This form is supplemental to the General Health and Intake Consent Form.**

Client Signature _____ Date _____

Therapist Signature _____ Date _____