CRANIOSACRAL THERAPY CLIENT INTAKE FORM

Please complete as thoroughly as possible. We take the privacy of our clients extremely serious, and the following information is kept private and confidential. This information will never be shared with an outside party without prior written consent of the client.

Date: *(mm/dd/yr)* _____ - _____ - _____

First Name: _____ Last Name: _____

Height: _____ Weight: _____ Date of Birth: (mm/dd/yr) _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Telephone: Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

E-mail: _____ Occupation: _____

How did you hear about us? *Please specify:*

_____

If referred, please indicate their name: _____

Name of your Family Physician: _____

When was your last check up? *(mm/dd/yr)* _____ - _____ - _____ Results? _____

Have you ever received professional CranioSacral Therapy before? Yes _____ No _____

If yes, when was the last time? *(mm/dd/yr)* _____ - _____ - _____

Do you have any current condition that causes increased cranial pressure, such as a recent concussion or stroke?

Yes _____ No _____ I am not sure _____

Purpose of your visit:

☐ enhance health and wellness balancing ☐ to address specific health concerns

(please specify): _____

_____

Any serious falls or injuries? If so, when: *(dd/mm/yr)* _____ - _____ - _____

_____

Any surgeries? If so, when: *(dd/mm/yr)* _____ - _____ - _____

_____

Any spinal problems? If so, please describe:

_____

_____

Are you pregnant? If so, how many weeks? Complications?

_____

_____

If you are taking any prescribed medications or regular supplements, please list:

_____

_____

Are you involved in sports or exercise on a regular basis? If so, please describe:

_____

_____

Please check any of the following health concerns that apply to you now or in the past:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive or Gastrointestinal
- ☐ Thyroid Disease
- ☐ Menopause
- ☐ Postpartum
- ☐ PCOS
- ☐ Fibromyalgia
- ☐ Seizures or Epilepsy
- ☐ Stroke or TIA
- ☐ Vertigo
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Sleep Disturbances/Sleep Apnea
- ☐ Snoring
- ☐ Open Mouth Breather
- ☐ Hearing Impairment
- ☐ Frequent Ear Infections
- ☐ Tinnitus
- ☐ Sinus Infections
- ☐ Eye Problems/Nystagmus
- ☐ TMJ
- ☐ Grinding or Clenching Jaw
- ☐ Oral Tie(s) – Tongue, Lip, or Buccal
- ☐ Dentures or Braces
- ☐ Dental Surgeries
- ☐ Headaches/Migraines
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Memory Concerns
- ☐ Anxiety
- ☐ Depression
- ☐ Trauma/PTSD/C-PTSD
- ☐ Current Open wounds
- ☐ Contagious disease
- ☐ Contagious skin condition

Any other physical or mental conditions to be aware of before proceeding with a CranioSacral Therapy session? If so, please describe:

_____

_____

Do you have any allergies or sensitivities to essential oils or scents? If so, please describe:

_____

_____

What are your goals or intentions for your CranioSacral therapy session? Please check any box that applies:

☐ pain relief

☐ relaxation

☐ boost immune function

☐ continued healing

☐ mental focus/meditation

☐ central nervous system regulation

☐ sleep better

☐ emotional release

☐ address trauma/PTSD concerns

☐ recovery from surgery

☐ body-mind awareness

☐ other, (please specify): _____

_____

Please read and initial each section and sign below.

_____ I understand that the CranioSacral therapist does not diagnose illness, disease, or any other physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals.

_____ I understand that CranioSacral therapy is considered to be a contraindication for ***recent*** injuries to the neck and head such as recent whiplash or fracture near the base of the neck, concussions, hemorrhages, or strokes. Currently, I am not experiencing any of these conditions.

_____ I understand that CranioSacral therapy is not a substitute for medical examinations and/or diagnosis for any physical ailment that I might have.

_____ I understand that it is necessary for the CranioSacral therapist to be aware of any existing physical conditions. I have stated above all my known medical conditions and intend to keep the CarnioSacral therapist updated on my physical health for future sessions. I release the therapist from responsibility and liability for any adverse reactions resulting from the disclosed and undisclosed physical conditions.

_____ I agree to give no less than a 48-hour notice if I choose to reschedule or cancel an appointment. If I cancel with less than a 48-hour notice or do not show up to my appointment, I agree to pay a 50% rebooking fee. If I cancel with less than a 24-hour notice or do not show up to my appointment, I agree to pay a 100% rebooking fee.

By signing and submitting this form, I affirm that I have read it completely, understand it and have accurately completed the above information and take responsibility for the answers and statements listed above.

Signature: _____ Date: *(mm/dd/yr)* _____ - _____ - _____