YOUNG ADULT CLIENT INFORMATION (age 12-17) Parent please fill in as applicable and sign on 2nd page.

Name of patient____ DOB:______________________

Name of Parent/s:____

Parent Contact number/s ____

Address__________________________________City_______________________State/Zip__________________

Parent Email Address____

Referred by:____ May I thank them:___Y / N__

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Has the patient received Craniosacral therapy in the past? Yes / No Date of last treatment:_____________

For what condition/s?____

What is the reason for this appointment today? (anxiety, headache, pain, concentration, injury, etc)

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Does the patient have a medical diagnosis?____

Is there any recent crisis or stressor happening that is significant to the patient's development?

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Is the patient receiving any other intervention / treatment / therapy? Yes / No If so, what?

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Has the patient had corrective surgery for strabismus or other eye motor difficulties? Y / N

Has the patient had COVID? Y / N When?___________ COVID vaccine(s)? Y / N When? _____________

Lingering symptoms of COVID and/or vaccine? ____

Any additional information, observations, symptoms, or health history that you feel is relevant or significant.

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Do you have any other concerns or questions about CranioSacral Therapy?

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Other relevant medical history. Please circle any of the following which currently apply to you; mark any that occurred in the past with a “P”.

Allergies	Aneurysm*	Arthritis	Asthma
Balance problems	Blood clots	Braces / palate exapnder	Brain fog
Bronchitis / Pneumonia	Cancer	Cerebral hemorrhage*	Chronic Pain
Clenching / grinding	Depression	Diabetes	Dizziness / Vertigo
Ear noises/popping	Epidural leaks*	Female Issues	Fibromyalgia
Fibrotic cysts	Fracture of spine or skull*	Heart condition	High/Low BP
Hip Replacement	Joint disease	Loss of taste / smell	Male Issues
Numbness	Osteoporosis*	Pacemaker	Poor Circulation
Pregnant	Respiratory/lung	Rheumatoid arthritis*	Sciatica
Scoliosis	Seizures	Sinus issues	Sleep issues
Speech Issues	Stroke*	Stress / anxiety	Swallowing issues

Please list any other conditions, symptoms, or health history that you feel is significant:

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CONSENT FOR CARE

You have the right to seek a second opinion or to end the therapy session at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist (Emily Klik LMT CST) for information about her training and credentials.

I, ________________________________, understand that CranioSacral Therapy is not a substitute for standard medical care, and I have indicated all of my known medical conditions. I will alert the practitioner to any changes in my health status, including medication changes. It is my choice to receive CranioSacral Therapy with an understanding of the risks and benefits, and I give my consent for treatment. I understand that there is no stated guarantee for effectiveness of treatment.

Signature____Date_____________

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Fee is a sliding scale of $90-150 per hour session. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness, complications of illness, weather-related events and true emergencies). In the present pandemic, there is no fee for late notice cancellations in the Skokie office.

As a wellness service, Craniosacral Therapy and Massage Therapy are not covered by most health insurance policies.

Please initial understanding of payment policy: ____________