Child / Pre-teen (age 4-12) CranioSacral Therapy by Emily Klik, LMT CST-D

Parent / guardian please fill in as applicable and sign on the 2nd page. Thank you.

Name of minor client_____ DOB _____

Name of parent / guardian _____

Address _____City _____State/Zip _____

Parent cell phone _____Other contact number _____

Parent email contact_____Referred by _____

Has the minor client received Craniosacral therapy in the past Y / N Date of last treatment: _____

For what condition/s _____

Please describe the reason for this appointment. (development issue, headache, injury, sinus issues etc)

_____

_____

Please circle any that apply:

Vaginal birth	Epidural	Premature birth	Tongue tie ~ revised
C-section	Vacuum	IVF/ IUI	Lip tie up/ low ~ revised
VBAC	Forceps	Latch/ suck issues	Buccal tie R / L / B ~ revised
Induced birth	Long labor _____	Newborn jaundice	
Stress/ anxiety	Sinus issues	Dizziness / Vertigo	Loss of taste/ smell
Brain fog	Speech / swallowing issues	Clenching / grinding / TMJ	Braces/ palate expander
Sleep issues	Balance issues	Tinnitus/ ear noises	Long-covid
Stroke	Aneurysm	Epidural leaks	Osteoporosis
Cerebral hemorrhage	Fracture of spine or skull	Chiari Malformation	

Does the minor client have a medical diagnosis? _____

_____

Please describe any recent or current crisis or stressor that is significant to the minor client's development.

_____

_____

Is the minor client receiving any other intervention / treatment / therapy? Yes / No

If so, please describe _____

Has the minor client had corrective surgery for strabismus or any other eye-motor difficulties? Y / N

Please list any surgical procedures, including dental, appendectomy, cyst removal, ENT procedures, etc:

_____

_____

Please list any additional information, observations, symptoms, or health history that is relevant or significant to this therapy. Including precautions, allergies, sensitivities, preferences, etc.

_____

_____

_____

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 for information about their training and credentials.

I, _____, understand that CranioSacral Therapy is not a substitute for standard medical care, and I have indicated all of the minor client's medical conditions. I will alert the practitioner to any changes in their health status, including medication changes. It is my choice to authorize the minor client to receive CranioSacral Therapy with an understanding of the risks and benefits, I release and hold harmless Emily Klik, North Shore Wellness Collective, Pelvic Health and Wellness, and MetaMassage and Bodywork from any present and future claims. I understand that there is no stated guarantee for the effectiveness of treatment. I voluntarily agree to assume responsibility for those risks, and I give my consent for treatment for the minor client.

Parent/ guardian signature_____Date_____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance.

Fee per session: $ 75/30 minutes, $100 / 60 minutes, and $ 150/ 90 minutes. Late arrivals may not have treatment time extended, and will still be charged the full fee. Whenever possible, cancel or reschedule in advance, with exceptions for illness, weather, or true emergencies. Cancellations under 24 hours or missed appointments may incur a fee at the therapist’s discretion, equal to half the session price.

Parent/ guardian, please initial understanding of payment policy: _____

CranioSacral Therapy — Informed Consent for Emily Klik LMT CST-D

North Shore Wellness Collective • MetaMassage and Bodywork

What Is CranioSacral Therapy?
CranioSacral Therapy (CST) is a gentle, hands-on modality that releases tensions deep in the body to relieve pain and dysfunction and improve whole-body health and performance. CST techniques manually manipulate soft tissue in the body and the plates of the skull. Benefits of CST may include relaxation, stress reduction, enhancement of circulation and nerve function, improvement in range of motion, and reduction of tension, soreness, and pain.

Limitations and Adverse Reactions: CranioSacral Therapists/Bodyworkers/Massage Therapists do not diagnose medical diseases or prescribe medications, and cannot counsel clients about emotional or spiritual issues. CST is not a substitute for medical examination and treatment. If you experience symptoms that lead you to believe you have a medical condition, it is recommended that you visit a licensed physician for diagnosis and treatment.
CST may lead to adverse reactions in certain situations or when used with certain conditions or medications. Your therapist will evaluate your CST screening document and ask you questions to help ensure it is safe for you to receive CST, and may refer you to another professional if she is uncertain that CST will be of benefit to you. Please provide complete details of your medical conditions and medications during the health-intake interview — failure to disclose all medical conditions may place you at increased risk for adverse reactions.

Your Rights as a Client

- You have the right to prompt, professional service in an environment that is clean, private, and safe.
- You have the right to seek a second opinion or to end a therapy session at any time.
- You are entitled to information about the methods and techniques used in your evaluation and treatment, and may ask your therapist about their training and credentials.
- Your information is not shared with members of the public or other health-care providers unless you release it in writing or it is requested by a court of law.

Client Expectations Clients are expected to demonstrate good hygiene and to not use illegal drugs or alcohol before a session. Sexual behavior in any form, from the client or a guardian toward the therapist, is inappropriate and will result in termination of the session and refusal of further service.

Your CranioSacral Session At your initial visit, the therapist will review your CST screening document, discuss your goals for the session, and customize the session to meet your specific needs within the limits of her training and scope of practice. All therapy is performed fully clothed. Sessions are 60 minutes long, which includes intake document review during the initial visit; completing paperwork in advance is recommended to maximize your time with the therapist.

Informed Consent: By signing below, I acknowledge and agree to the following:

- CranioSacral Therapy is not a substitute for standard medical care, and I have indicated all of my known medical conditions.
- I accept responsibility to alert my practitioner to any changes in my health status, including changes in medication.
- It is my choice to receive CranioSacral Therapy with an understanding of the risks and benefits involved, and I voluntarily agree to assume responsibility for those risks. I give my consent for treatment.
- I release and hold harmless Emily Klik, North Shore Wellness Collective, Pelvic Health and Wellness, and MetaMassage and Bodywork from any past, present, and future claims.
- I understand that there is no stated guarantee of the effectiveness of treatment.

I have read and understand this information, and I would like to receive a CranioSacral Therapy session.
For minor clients, the provider requires that a parent or guardian remain in the room for the entire duration of the treatment session.

Client Signature: _____ **Date:** _____

Printed Name: _____ **Guardian Signature (if applicable):** _____

HIPAA Consent to Use and Disclose Health Information

By signing this form, I acknowledge that I have received a copy of Emily Klik LMT CST's Notice of Privacy Practices *(this form can be found on Emily Klik's website).*

-I request the following restrictions to the use or disclosure of my health information:

_____

_____

Signature_____ Date _____

Printed Name:_____

Client Date of Birth:_____

Client Name if signing for a minor child: _____

It has been my experience that some clients prefer email correspondence regarding their own or their child's care. Emily Klik does NOT have HIPAA-compliant (encrypted) email service. With this understanding, please initial:

_____I give my permission to correspond by email regarding my/my child's care and appointments.

_____I prefer phone correspondence only. These may include text messages.

If we are unable to speak with you directly by phone, is it okay for Emily Klik to leave detailed/clinical information and/or appointment reminders on your answering machine, if available?

____Yes ____No _____ Appointment reminders only

Release of Information (OPTIONAL)

I authorize Emily Klik LMT CST to release and/or discuss medical/healthcare information with:

_____ Relation:_____

_____ Relation:_____

The following individuals or facilities, in order to coordinate care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Signature:_____