

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 expander | 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 \$75-125 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:** \_\_\_\_\_