

CLIENT INFORMATION Please fill in as applicable and sign on 2nd page. Thank you. *Emily Kliik LMT CST*

PERSONAL INFORMATION:

Name: _____ DOB: _____

Address _____ City _____ State/Zip _____

Cell Phone _____ Other contact number _____

Email Address _____

Referred by: _____ May I thank them: Y / N

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Have you received Craniosacral therapy in the past? Yes / No Date of last treatment: \_\_\_\_\_

For what condition/s? \_\_\_\_\_

**Primary reason for your appointment**

\_\_\_\_\_

List areas of complaint, pain, or tension \_\_\_\_\_

How are these concerns affecting your function in life?

Work: \_\_\_\_\_

Leisure/Play: \_\_\_\_\_

Sleep/Self-Care/Appetite: \_\_\_\_\_

Do you have a medical diagnosis: \_\_\_\_\_

Are you now under medical/therapeutic treatment for this condition? Yes No

If so, what treatments? \_\_\_\_\_

Please list any precautions the therapist should be aware of: \_\_\_\_\_

Please list any medication/s you are taking (including over-the-counter)

\_\_\_\_\_

Please (date/describe) any hospitalizations or surgeries:

\_\_\_\_\_

Any significant injuries (accidents, fractures, etc./when, what, and treatments):

\_\_\_\_\_

On a normal day, how is your stress/ anxiety? (scale 1-10)\_\_\_\_\_

Where do you feel stress/ anxiety in your body? \_\_\_\_\_

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 / retainer           | Brain fog             |
| Bronchitis / Pneumonia | Cancer             | Cerebral hemorrhage*        | Chronic Pain          |
| Clenching / grinding   | Depression         | Diabetes                    | Difficulty swallowing |
| Dizziness / Vertigo    | Ear noises/popping | Epidural leaks*             | Female / Male Issues  |
| Fibromyalgia           | Fibrotic cysts     | Fracture of spine or skull* | Heart condition       |
| High/Low BP            | Hip Replacement    | Joint disease               | Loss of taste / smell |
| Numbness               | Osteoporosis*      | Pacemaker                   | Poor Circulation      |
| Pregnant               | Respiratory/lung   | Rheumatoid arthritis*       | Sciatica              |
| Scoliosis              | Seizures           | Sinus issues                | Sleep issues          |
| Stroke*                | Stress / anxiety   |                             |                       |

Have you had surgery to correct strabismus or eye movement difficulties? Yes / No

Please list any other conditions, symptoms, or health history that you feel are relevant:

\_\_\_\_\_

**Client/ Guardian 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, weather-related events and true emergencies); *presently there is no fee for late-notice cancellations. If this changes, you will be notified directly.*

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

**Please initial understanding of payment policy:** \_\_\_\_\_