PEDIATRIC PATIENT INFORMATION (age 5-11) **Please fill in and sign on the 2nd page.**

Name of child_____ DOB:_____

Name of Parent/s:_____

Address_____City_____State/Zip_____

Parent Cell Phone_____Other contact number_____

Parent Email Address_____Referred by:_____

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

For what condition/s?_____

What is the reason for this appointment? (development issue, headache, injury, sinus issues etc)

_____

Please circle any that apply:

Vaginal birth	Epidural	Premature birth_____	Issue with latch / suck
C-section	Vacuum	IVF	Tongue tie: revised?
VBAC	Forceps	IUI	Lip tie: up /low revised?
Stress / anxiety	Sinus issues	Dizziness / Vertigo	Loss of taste / smell
Brain fog	Speech/ swallowing issues	Clenching / grinding	Braces / palate expander
Sleep issues	Balance issues	Tinnitus / ear noises	Surgery
Stroke	Aneurysm	Epidural leaks	Osteoporosis
Cerebral hemorrhage	Fracture of spine or skull	Chiari Malformation	

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

_____

Does your child have a medical diagnosis?_____

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

_____

Is your child receiving any other intervention / treatment / therapy? Yes / No If so, what?

_____

Has your child had corrective surgery for strabismus or any other eye motor difficulties? Y / N

Has your child had COVID? Y / N When?_____

Are there any lingering symptoms of COVID?_____

Any other pertinent medical information, including precautions or allergies the therapist should be aware of?

_____

CONSENT FOR CARE

You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the session. You may also ask the therapist for information about her training and credentials.
I, _____, understand that CranioSacral Therapy is not a substitute for standard medical care. I will alert the therapist to any changes in my child's health status, including medication changes. It is my choice to receive CranioSacral Therapy for my child with an understanding of the risks and benefits, and I give my consent for treatment of my minor child. I understand that there is no stated guarantee for effectiveness of treatment.

Parent/ Guardian Signature_____Date_____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. CranioSacral therapy is a sliding scale of $90-150 where parent chooses the fee in that range. Partial hours are prorated at this rate after 30 minutes minimum. Late starts to appointment cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee.
Cancellations: Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness and weather-related events). Presently there is no fee or penalty for late notice cancellations in the Skokie office. Emily Klik will alert you of any change to this late notice policy.

Please initial indicating understanding of payment & cancellation policies:_____