CLIENT INFORMATION Please fill in as applicable and sign on 2nd page. Thank you. *Emily Klik 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):

____
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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:

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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 $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, weather-related events and true emergencies); *presently there is no feel 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: ____________