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 _____Alt contact _____

Email Address _____Referred by _____

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

For what condition/s? _____

Please describe the reason / s for this
appointment_____

_____

_____

Please describe how these concerns affect your activities of daily living, work, and downtime:

_____

_____

Please describe any medical diagnoses or conditions_____

Please describe any current or recent treatments, therapies, and medications _____

_____

Please describe any recent or current crisis or stressor _____

_____

_____

Have you had corrective surgery for strabismus or any other eye-motor difficulties Yes / No

Please describe any surgical procedures (including dental and ENT), significant injuries, accidents, hospitalizations or other traumas

_____

_____

On a normal day, please rate your experience of stress/ anxiety on a scale of 1-10, _____

Please describe how stress / anxiety show up 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
Back pain
Balance problems
Blood clots
BP high / low
Braces / retainer
Brain fog
Cancer
Cerebral-
-hemorrhage*
Chiari-
-malformation*
Chronic pain
Clenching / grinding
Depression
Diabetes
Difficulty swallowing
Dizziness / vertigo
Ear noises / popping
Ehlers-Danlos
Epidural leaks*
Fibromyalgia
Fibrotic cysts
Fracture spine / skull*
Headache
Heart condition
Joint disease
Joint replacement
Long covid
Loss of taste/ smell
Migraine
Neck pain
Numbness
Osteoporosis*
Pacemaker
Poor circulation
Pregnant
Rheumatoid-
-arthritis*
Rib pain
Sciatica
Scoliosis
Seizures
Sinus issues
Sleep issues
Spinal pain
Stress / anxiety
Stroke*
TMJ issues / pain

Please list any additional information, observations, symptoms, or health history that is relevant or significant to this therapy. Including precautions, allergies, sensitivities, preferences, long-covid symptoms, 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 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, I voluntarily agree to assume responsibility for those risks, and I give my consent for treatment. I release and hold harmless Emily Klik from any present and future claims. I understand that there is no stated guarantee for the 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 $100 per session. All sessions are scheduled for 60 minutes. There may be an additional fee for a house call that includes table setup and travel time. 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 and weather-related events); cancellations within 24 hours will be subject to a $60 cancellation fee at therapists' discretion.

Please initial understanding of payment policy: _____