PATIENT INFORMATION Please fill in as applicable and sign at the bottom. Thank you.

PERSONAL INFORMATION:

Name of baby_____ DOB:_____

Name of Parent/s:_____

Address_____City_____State/Zip_____

Parent Cell Phone_____Other contact number_____

Parent Email Address_____Referred by:_____

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

For what condition/s?_____

Please circle any that apply, feel free to give details below:

Vaginal birth	Epidural	Premature _____	Issue with latch or suck reflex
C-section	Vacuum	IVF _____	Tongue tie: revised?
VBAC	Forceps	IUI	Lip tie: upper /lower revised?
Induced birth	Long labor_____	Newborn jaundice	Home birth

What is your reason for this appointment? (colic,feeding issues, complicated birth, etc)_____

_____

Any information or observations around the birth process that you feel are important and/or relevant_____

_____

_____

Please detail any other conditions, symptoms, or health history that you feel is relevant:

_____

_____

Does your child have a medical diagnosis?_____

Name of school child attends (if applicable)_____Grade:_____

Is there any recent crisis or stress going on that is important / significant to your child's development?

_____

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

_____

Primary Physician or Practitioner's name_____Tel #: _____

Please list any medications (including over-the-counter):

_____

Has your child had corrective surgery for strabismus or eye motor difficulties? Yes No

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 CranioSacralTherapy 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. The fee for CranioSacral therapy is a sliding scale of $90-150 per session, 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 let Emily Klik know as soon as possible if it is necessary to cancel or reschedule any appointments, especially if any symptoms of illness (outside of allergies) emerge prior to the appointment. Presently, due to the pandemic, there is no fee for late-notice cancellations. If this policy changes, Emily will notify you directly.

Parent/ guardian please initial indicating understanding of payment & cancellation policies:_____