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:____________________________

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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? ____

Physician or Practitioners name___________________________________Tel #: _________________

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:

_____

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, and I give my consent for treatment. I understand that there is no stated guarantee for 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 $80 per hour session. There may be an additional fee for a house call that includes table setup and travel time. 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 $40 cancellation fee at therapists' discretion.

Please initial understanding of payment policy: _____