Client Information for CranioSacral Therapy

Date___/___/____

Name _____ Date of Birth ___/___/_____

Address_____ City _____ State_____ Zip _____

Home Phone (____)_____ Cell (____)_____ Best number to call: ___ home ___ cell

Email: _____ Referred by: _____

In Case of Emergency _____ Phone (____)_____

Occupation _____ Under Chiropractic Care ___ No ___ Yes How long? _____

Please take a minute to carefully read the following information and sign where indicated. If you have a specific condition or specific symptoms, CST/bodywork may be contraindicated. Do you (have)/Are you:

__Yes __No suffering from stress?
__Yes __No any broken bones in the past?
__Yes __No frequent headaches?
__Yes __No any accidents or injuries or traumas?
__Yes __No currently wearing contact lenses?
__Yes __No birth trauma/ assisted delivery?
__Yes __No back pain?
__Yes __No joint swelling?
__Yes __No a contagious disease?
__Yes __No any allergies?
__Yes __No whiplash?
__Yes __No bruise easily?
__Yes __No diabetes?
__Yes __No vertigo?

__Yes __No currently pregnant?
__Yes __No have children?
__Yes __No epilepsy or seizures?
__Yes __No arthritis?
__Yes __No high blood pressure?
__Yes __No if yes to above, taking meds?
__Yes __No heart or circulatory issues?
__Yes __No varicose veins?
__Yes __No osteoporosis?
__Yes __No ever had surgery?
List:_____
_____
__Yes __No Head Impacts/ Injuries?
List: _____

Do you have areas of soreness, tension or sensitive to touch? If yes, explain:

_____

Do you have numbness or stabbing pains anywhere? If yes, explain:

_____

Do you have any other condition, or are taking any medications not mentioned above?

_____

Comments:

_____

I understand that the CST/bodywork I receive is provided for the purpose of relaxation, relief of muscular tension, general health and wellbeing improvements. If I experience any pain or discomfort during this session or any future sessions, I will immediately inform the practitioner so that the pressure and/or positioning may be adjusted to my level of comfort. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified specialist for any mental or physical ailment of which I am aware. I understand that CST/bodywork practitioners do not preform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given shall be construed as such. Because bodywork should not be performed under certain health conditions, I affirm that I have stated all my known health conditions and answered all questions honestly. I agree to keep the practitioner updated with any changes to my health profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date ____/____/____