**CranioSacral Therapy (CST) and CranioSacral Fascial Therapy (CFT)**

**Client Information Form**

*Confidentiality: All information on this questionnaire will be kept strictly confidential.*

**Name: Email:**

**Address:**

**Phone (best way to reach you):**

**Age/DOB:**

**Occupation:**

**Referred by:**

**Emergency contact person/phone**:

Have you previously experienced CST or CFT?

Primary reason for today’s visit:

Areas of complaint, pain, tension:

In a few words, please describe your goal for this session:

Are you aware of any emotional distress from the time of an injury?:

Have you suffered any form of abuse your body may be holding?:

*Please answer yes or no to the following:*

Y N Do you wear contact lenses?

Y N Dentures?

Y N Tongue, lip of buccal ties - revised or diagnosed?

Y N Have you had extensive dental work (braces, etc)?

Y N Car accident, serious fall or injuries?

Y N Do you have any allergies? If so, please describe allergens:

Y N Do you have arthritis? What type/where? Please describe:

Y N Do you have any heart problems? What type/where?

Y N Do you have any spinal problems? What type/where?

Y N Are you presently pregnant? How far along? Complications?

Y N Have you had surgery? Recently? Complications?

Y N Do you take prescribed medications? Please list:

Y N Do you exercise or play sports on a regular basis? Please describe:

Y N Are you receiving any other complementary care (chiropractic, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? Please describe:

Y N Do you have any other physical or mental condition of which I should be aware before giving you a CranioSacral session? If yes, please describe:

**Please list supporting providers (first and last name):**

Lactation Consultant:

Chiropractor:

Pediatrician:

Dentist if TT released:

Other:

*Please read and initial:*

\_\_\_\_\_\_\_\_\_ I understand that the CranioSacral bodyworker does not diagnose illness, disease or any other physical or mental disorder. In addition, the CranioSacral bodyworker does not prescribe medical treatment of pharmaceuticals.

\_\_\_\_\_\_\_\_\_ I understand that the craniosacral bodyworker is considered to be a contraindication for recent injuries to the head and neck, ie; whiplash, any recent fracture to base of the neck, concussion, hemorrhage, as well as rheumatoid arthritis, and state that I am not currently experiencing any of these conditions.

\_\_\_\_\_\_\_\_\_ It has been made very clear to me that craniosacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

\_\_\_\_\_\_\_\_\_ Because a craniosacral bodyworker must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the craniosacral bodyworker updated on my physical health. Further, I release the bodyworker from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

\_\_\_\_\_\_\_\_\_ Payment is due at time of visit. I understand that I will be financially responsible for a missed or rescheduled appointment if not cancelled/changed by phone/text 24 hours prior to the reserved session time.

\_\_\_\_\_\_\_\_\_\_ I authorize the bodywork practitioner to speak with other healthcare providers that are involved in my care if needed.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

*I have completed the above information accurately and have read, understand, and take responsibility for the above statements*..

*Therapist notes:*