Soulful Truth

Integrative Healing, Craniosacral Therapy

Client Information Form

Name: ________________________________
Birth Date: _____________________________
Address: ____________________________________ City ______________ State _____ Zip _________

Preferred Contact Method: o (Cell) __________________ o (E-mail) _____________________________
Occupation: ____

Referred by: ____

Emergency contact person: ___________________________________ Phone: ____________________

Have you previously experienced Craniosacral Therapy? □ Yes | □ No

Are you currently under a physician's care for any condition? □ Yes | □ No
Please describe:____
Physician's name: _____________________________ Phone: ________________

Primary reason for today's visit, (please explain):____
____

Areas of complaint, pain, tension, (please explain): ____
____

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

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

Please answer the following questions:

Do you wear contact lenses? □ Yes | □ No
Do you wear dentures? □ Yes | □ No
Have you had extensive dental work (ie; braces, etc.)? □ Yes | □ No
Car accident (at any time), serious falls or injuries? □ Yes | □ No
Do you have a history of seizures or a seizure disorder? □ Yes | □ No
Have you had an aneurysm? □ Yes | □ No

Do you have any allergies? If so, please describe allergens: □ Yes | □ No
____

Do you have arthritis? What type and where? Please describe: □ Yes | □ No

____

Do you have any heart problems? Please describe: □ Yes | □ No

____

Do you have any spinal problems? Please describe: □ Yes | □ No

____

Are you presently pregnant? How far along? Complications? □ Yes | □ No

____

Have you had surgery? How recently? Complications? □ Yes | □ No

____

Do you take any prescribed medications? Please list: □ Yes | □ No

____

Do you exercise or play sports on a regular basis? Please describe: □ Yes | □ No

____

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: □ Yes | □ No

____

Please read and initial:

I understand that the Craniosacral therapist does not diagnose illness, disease, or any other physical or mental disorder. In addition, the Craniosacral therapist does not prescribe medical treatment or pharmaceuticals ______

I am not currently experiencing any of these conditions: recent injuries to the head and neck, ie; recent whiplash, any recent fracture to base of the neck, concussion, hemorrhage, aneurysm ______

I am aware 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 therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Craniosacral therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions. _______

Signature: ____ Date: ________________

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