Awakening Touch MASSAGE

CranioSacral Therapy for Adolescence

Patient name_____Parent/Guardian name_____ Date_____
Address
City State Zip
E-Mail Child's Date of Birth
Cell Phone Home Phone
Referred by
Emergency contact Phone number

Has child previously experienced CranioSacral Therapy? YES ◯ NO ◉

Is child currently under a physician's care for any conditions? YES ◯ NO ◉

If yes, please describe _____

_____

Primary reason for today's visit? _____

_____

Areas of complaint, pain, tension? _____

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Child's goal for this session? _____

_____

Are you aware of any emotional distress flowing from the child's injury? _____

_____

Any secondary complaints you would like to address? _____

_____

How and when did the child's major symptoms begin? (result of an accident, injury, or did they begin spontaneously?)

_____

_____

_____

Has the child ever received any other treatments for this condition? (Chiropractic, Naturopathic, Acupuncturist, etc.)

_____

Is the child comfortable with your therapist asking personal questions as they pertain to your session?

_____

Does the child have other physical or mental condition I should be aware of before receiving CranioSacral Therapy?

_____

How would you describe the child's activity level? (i.e. exercise, sports, etc.)

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Please leave blank or circle if applies:	**C** for current, **P** for past issues

Headaches	C ☐	P ☐	Sinus problems.	C ☐	P ☐
Migraines	C ☐	P ☐	Facial pain	C ☐	P ☐
Jaw problems	C ☐	P ☐	Closed head injury	C ☐	P ☐
TMJ	C ☐	P ☐	Sciatica	C ☐	P ☐
Whiplash	C ☐	P ☐	Back pain	C ☐	P ☐
Vision problems	C ☐	P ☐	Difficulty sleeping	C ☐	P ☐
Neck problems.	C ☐	P ☐	Anxiety.	C ☐	P ☐
Ear problems	C ☐	P ☐	Panic attacks.	C ☐	P ☐
Hearing problem.	C ☐	P ☐	Depression.	C ☐	P ☐
Tinnitus	C ☐	P ☐	Mood swings.	C ☐	P ☐
Ringing in ears	C ☐	P ☐	Shunt	C ☐	P ☐
Dizziness	C ☐	P ☐	Physical/mental/. Sexual abuse	C ☐	P ☐
Development Delays.	C ☐	P ☐	Birth trauma.	C ☐	P ☐

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DISCLOSURE AND CONSENT

Please thoroughly read the following paragraphs and then initial each paragraph after reading.

_____I understand that CranioSacral Therapy (CST) does not diagnose illness, disease or any other physical or mental disorder. In addition, the cranial sacral therapist does not prescribe mental treatment or pharmaceuticals.

_____ I understand that CranioSacral Therapy (CST) is considered to be a contraindication for recent injuries to the head and neck, i.e.; recent whiplash, any recent fractures to the base of the neck, concussions, hemorrhage, as well as rheumatoid arthritis. I state that I am not currently experiencing any of these conditions.

_____ It has been made very clear to me that CranioSacral Therapy (CST) is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical elements that I might have.

_____ Because a CranioSacral Therapist (CST) must be aware of existing physical conditions, I have stated all my known medical conditions and take upon myself to keep the CranioSacral Therapist (CST) updated on my physical health. Further, I release the CST therapist from responsibilities and liabilities for any adverse reactions resulting from disclosed and undisclosed conditions.

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

Signature_____ Date_____

CANCELLATION POLICY

A 24-hour advance notice is required when canceling any appointments, expect in case of illness or emergency. Cancellations without 24-hour notice will result in full payment charges.

I have read and understand this cancellation policy.

Signature_____Date_____