Awakening Touch MASSAGE

CranioSacral Therapy

Name	Date
Address	
City	State Zip
E-Mail	Date of Birth
Cell Phone	Home Phone
Occupation	Referred by
Emergency contact	Phone number

Have you previously experienced CranioSacral Therapy? YES ◯ NO ◉

Are you 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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Your goal for this session? _____

Are you aware of any emotional distress flowing from your injury? _____

Any secondary complaints you would like to address? _____

How and when did your major symptoms begin? (result of an accident, injury, or did they begin spontaneously?)

Have you ever received any other treatments for this condition? (Chiropractic, Naturopathic, Acupuncturist, etc.)

Are you comfortable with your therapist asking personal questions as they pertain to your session?

Do you have other physical or mental condition I should be aware of before receiving CranioSacral Therapy?

How would you describe your 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

	C	P
Headaches	☐	☐
Migraines	☐	☐
Jaw problems	☐	☐
TMJ	☐	☐
Whiplash	☐	☐
Vision problems	☐	☐
Neck problems	☐	☐
Ear problems	☐	☐
Hearing problem	☐	☐
Tinnitus	☐	☐
Ringing in ears	☐	☐
Dizziness	☐	☐

	C	P
Sinus problems	☐	☐
Facial pain	☐	☐
Closed head injury	☐	☐
Sciatica	☐	☐
Back pain	☐	☐
Difficulty sleeping	☐	☐
Anxiety	☐	☐
Panic attacks	☐	☐
Depression	☐	☐
Mood swings	☐	☐
Shunt	☐	☐
Physical/mental/ Sexual abuse	☐	☐

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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 understood this cancellation policy.

Signature_____Date_____