Craniosacral Therapy and Reiki Healing Intake Form

Please complete this required form before your session as thoroughly as possible. The information provided is kept confidential. Date: _____

Pediatric Clients Only: Baby/Child Name: _____ Age today: _____

Birth Height:_____ Birth Weight:_____ Date of Birth: (dd/mm/yr) _____

Length of pregnancy: _____ Natural or Cesarian:_____

Complications during delivery: _____

First & Last Name: _____

Height:_____ Weight:_____ Date of Birth: _____

Address _____

Telephone: (Home) _____ (Cell) _____

How did you hear about us? Please specify: _____

If you are referred, please indicate the name of the person who referred you:

_____

What brings you in today? Check or circle from the list below.

Pediatric CST:

□ to address symptoms of PTSD or other Trauma?
□ issues with breastfeeding?
□Difficulty sleeping?
□Issues with bowel movements?
□Injury from accident or physical trauma?
□ Other: _____

Teen and Adult CST:

□ to relieve headaches, migraines?
Do you experience headaches often? If so, please describe: _____
□ Sports injury or mobility issues?
□ to relieve tension from braces?
□ relief for dental work/procedures or TMJ?
□ To aid anxiety or stress related disorders?
□ to address symptoms of ADHD or other learning challenges?
□ to address specific health concerns? (please specify):_____

Briefly detail any trauma event in your life: death, accidents, attacks, etc:

_____

Any serious falls or injuries? If so, when: _____

Any surgeries? If so, when: _____

Any spinal problems? If so, please describe:_____

Are you pregnant? If so, how many weeks? Complications? _____

If you are taking any prescribed medications, please list: _____

Are you involved in sports or exercise on a regular basis? _____

Any other physical or mental conditions to be aware of before proceeding with a Craniosacral/Reiki session?

If so, please describe: _____

Please read and initial:

_____ I understand that Amber Cotton does not diagnose illness, disease, or any other physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals.

_____I understand that any self-care suggestions that are made by Amber Cotton are to be done at your own risk.

_____ I understand that Craniosacral therapy is considered to be a contraindication for recent injuries to the neck and head such as recent whiplash or fracture near the base of the neck, concussions or hemorrhages. Currently, I am not experiencing any of these conditions.

_____ I understand that Craniosacral therapy/ Reiki is not a substitute for medical examinations and/or diagnosis for any physical ailment that I might have.

_____ I understand that it is necessary for Amber Cotton to be aware of any existing physical conditions. I have stated above all my known medical conditions and intend to keep her updated on my physical health for future sessions. I release Amber Cotton from responsibility and liability for any adverse reactions resulting from the disclosed and undisclosed physical conditions.

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

Signature: _____ Date: _____

Please mark any areas of concern.