CLIENT INFORMATION (PLEASE PRINT)

NAME:_____ TODAY'S DATE:_____

DATE OF BIRTH:_____

EMAIL ADDRESS: _____

CURRENT GENDER IDENTITY: _____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

PHONE: CELL:_____HOME/WORK:_____

May we leave voicemail / text messages on your home, cell or work numbers: Yes/No

Please specify if text or voicemail and to which number: _____

In case of emergency, may we leave a message with spouse, partner or other persons (state name/relationship): Yes/No

NAME OF SPOUSE OR PARTNER or SUPPORT PERSON:

_____

IF REFERRED BY, PLEASE LIST:(Patient / Therapist / Doctor - Name & Phone):

_____

Describe the reason you have come here and the symptoms you are experiencing:_____

_____

_____

Date of injury or onset of illness:

_____

What makes the problem worse:

_____

What makes the problem better:

_____

What other treatments have you received for this problem:

_____

If an accident, list type (auto, workers comp., personal injury, etc.):

_____

List all prescription and non-prescription medications you are currently taking:

_____

_____

List any allergies that you have:

_____

_____

List and date surgeries/hospitalizations:

_____

_____

_____

IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING, PLEASE LET ME KNOW IMMEDIATELY AND BEFORE WE BEGIN ANY TREATMENT AS THESE MAY BE CONTRAINDICATED WITH CRANIOSACRAL THERAPY:

- RECENT CONCUSSION
- CEREBRAL SWELLING
- STRUCTURAL DEFICITS IN THE CEREBELLUM SUCH AS ARNOLD-CHIARI MALFORMATION
- EHLERS-DANLOS SYNDROME
- BRAIN ANEURYSM
- TRAUMATIC BRAIN INJURY
- BLOOD CLOTS
- ANY DISORDER THAT CAUSES INSTABILITY IN OF CEREBRAL FLUID PRESSURE, FLOW, OR BUILD UP.

Additional Comments:

_____
_____
_____

*****Please be advised that Medicare will not pay for CranioSacral Therapy for the reason(s) noted:**

Description of Service(s): 97799 CranioSacral Therapy Reason(s) for Medicare's denial: Not Covered Services.

Please refrain from wearing perfume, cologne or other scents

**Payment is required at the time of service and you are responsible for all fees.

**Please provide a 24 hours cancellation notice if you are unable to keep your appointment. If we are not notified 24 hours in advance, we will charge you for your missed appointment .

MY SIGNATURE CONFIRMS THAT I AM AWARE OF AND AGREE TO THE ABOVE.

SIGNATURE:_____DATE:_____

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IF THE PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

NAME OF LEGAL PARENTS OR GUARDIAN:_____
EMPLOYERS OF PARENTS/GUARDIAN: _____
OCCUPATION:_____
EMPLOYER ADDRESS: _____
PHONE:_____