**Path into the Heart**
**Pediatric CranioSacral Therapy Health Intake and Liability and Release**

Child's Name:_____ Age _____

Parent or guardian's name:_____

Date:_____ Birthdate:_____

Address:_____

city/state _____Postal Code _____

Email Address:_____

Phone:_____

Emergency Contact:_____

Emergency contact phone: _____

Were you referred to this office? (Y/N)

By Whom? _____

What is the reason for your visit?_____

_____

_____

_____

_____

_____

Has your child had any previous treatment for this condition?_____

_____

_____

_____

What makes it better?_____

_____

_____

_____

What makes it worse?_____

_____

_____

_____

What other types of treatments are you currently receiving? (Chiropractic, Massage, Acupuncture, etc.) _____

_____

_____

_____

Who is your family physician?_____

Are you seeing any specialists?_____

_____

What medications is your child currently taking?_____

_____

_____

_____

Please list any major surgeries, injuries, or illness that your child has experienced and when they occurred: _____

_____

_____

_____

_____

_____

Is there anything about your child's birth and delivery or development that you would like me to know? _____

_____

_____

_____

_____

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Is there anything else you would like me to know?

_____

_____

_____

_____

**Liability and Release**

I understand that the CranioSacral Therapy my child or I receive is provided for the basic purpose of relaxation and relief of physical tension. I understand that any treatment may present some unwarranted risk of injury. I understand that Somato Emotional Release is a natural part of Craniosacral Therapy which provides gentle trauma resolution for relief of emotional or energy restrictions in the body. Working with the tissues of the body may or may not bring up past trauma, memories, past and present experiences that is significant or insignificant to healing. I understand that craniosacral therapy works on the physical/emotional/and spiritual level and may or may not experience a variety of different effects that are very individual to the receiver in the day/days after the session. If I or my child experience any pain or discomfort during this session, I will inform the practitioner.

I agree to release Meredith Guthrie LMT / Path into the Heart LLC from any liability of injury, demand, claim, or cause of action of any kind that happens during a craniosacral therapy session, or during the course of my treatment or while on the premises of Path in the Heart LLC office site, including but not limited to, the inside and outside premises/parking lot.
I further understand that bodywork should not be a substitute for medical examination, diagnosis, or treatment, and that I or my child should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that bodywork practitioners are not qualified to preform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness.

I affirm that I have stated all my or my child's known medical conditions and answered all questions honestly. I agree to keep practitioner updated to any changes that occur in my body, my child's body, or medical conditions and that there should be no liability on the practitioner's part if I fail to do this. I understand that cancellations without 24 hours in notice will be charged a $50 cancellation fee per one hour, and cancellation 2 hours before and no shows will be charged full amount. I also understand that late arrivals will be charged for full amount of service time.

*** your email that was used to book the appointment will be kept on file with me in the Acuity/Squarespace system and kept private. You may receive emails and have the option to unsubscribe at the bottom of emails.

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Print child's name _____

Print parent or guardian's name _____

Signature or parent or guardian_____

Date _____