

Craniosacral Therapy Consent & Acknowledgment Form

Client Name: _____

Date of Birth: _____

Phone/Email: _____

I understand that craniosacral therapy is a gentle, non-invasive, hands-on approach intended to support the body's natural healing processes. I acknowledge that:

- Craniosacral therapy is not a diagnostic tool, medical treatment, or substitute for appropriate medical or psychological care.
- No medical diagnosis or treatment will be offered or implied.
- This therapy is designed to support relaxation, nervous system balance, and overall well-being.
- I should consult my physician or qualified health provider for any specific medical concerns.

I also understand that I may stop the session at any time and that all sessions are strictly confidential.

Signature of Client (or Parent/Guardian): _____ Date: _____

Therapist Signature: _____ Date: _____