Lisa Wengerd, Certified CranioSacral Therapist
Stillpoint Integrative Healing

Client Information

Name_____Date_____

Address_____City_____State_____Zip_____

Contact Phone: Home: _____Cell:_____Email_____

Date of Birth_____Emergency contact_____

Occupation_____

Referred by _____
(Patient, Therapist, Doctor, PT/OT, Chiropractor, etc. including name and phone number)

Medical History/Lifestyle

Have you ever had CranioSacral Therapy? **Y** or **N** How would you describe your current health?

Excellent **Very Good** **Good** **Fair** **Not so fair**

Reason(s) for receiving CST and the symptoms you are experiencing (physical and emotional):

_____

_____

Date of injury/onset of illness/issue: _____

What other treatments have you received for this issue? _____

List and date surgeries/hospitalizations:

Reason **Date**

_____

_____

If you are undergoing medical treatment, please describe the reason, and include your physician's name and number:

_____

_____

List any allergies you may have:

_____
_____
_____

List any prescription/non-prescription drugs and supplements you are taking:

_____
_____
_____

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Session Information

*During your session(s), please refrain from wearing perfume, cologne and/or other scents.

*Please be advised that Medicare/Medical Insurance does not pay for CranioSacral therapy: it is not a covered service.

*Please provide 24 hours' cancellation notice if you are unable to keep your appointment. Otherwise, we reserve the right to charge for your session.

*Payment is required at time of service.

I understand and agree that the CST/MT provided by Lisa Wengerd, CST, LMT and Stillpoint Integrative Healing are provided pursuant to and in accordance with the laws of New Mexico governing this therapy and that full and complete medical history disclosure is essential in providing such therapy. I agree to hold harmless, and release Lisa Wengerd, CST, LMT and Stillpoint Integrative Healing against any and all liability arising from the application of CST/MT. By signing this release, I state that I have provided all relevant information necessary for the proper application of CST/ MT and I give my permission for Lisa Wengerd, CST, LMT and Stillpoint Integrative Healing to provide such therapy. By signing, I accept responsibility for full payment of my account and payments expected at time of service.

Signature_____Date_____

If patient is under 18 years of age, please complete the following:

Parent or Legal Guardian name_____

Parent or Legal Guardian employer_____

Please indicate by checking each of the following that apply (in your history and presently):

P=presently, H=in history

__Aids/HIV __Allergies __Anemia __Anorexia __Arthritis: ☐ Osteo- ☐ RA __ Arteriosclerosis __Asthma __ADD __ADHD __ASD (Autistic Spectrum) __Back Pain __Bronchitis __Blood Pressure: ☐ Hi ☐Low __Blood Clots __Bone spurs __Bulimia __Bursitis	__Cancer __Carpal Tunnel __Chemical dependency __Circulatory Disorders __Colitis __Decubitis ulcers __Depression __Deteriorated/Herniated disks __Diabetes __Digestion/Elimination __Dizziness __Epilepsy __Fractures __Gout __Headaches __Heart Condition/Disease __Head injuries	__Hemophilia __Hepatitis __Hypoglycemia __Intestinal Disorders __Joint Replacement __Kidney Disease __Liver Disease/Issues __Lung/Respiratory __Miscarriage __Motor skills functions __Muscle spasms __Neck pain __Nerve Damage __Nervousness __Numbness ☐Hands ☐Feet ☐ Other_____ __Osteoporosis	__Phlebitis __Pinched nerve(s) __Pregnancy __Ringing in ears __Sciatica __Scoliosis __Sinus difficulties __Seizures __Sensory Integration Issues __Skin problems __Stroke __TMJD __Tuberculosis __Tumors __Urinary Tract Infection __Varicosities __Whiplash

Circle any area below where you are experiencing pain or discomfort.