PATIENT INTAKE FORM

Client Name:		Date of Birth:
Parents/Guardian Name *(if client is a minor)*		
Address:		
Home Phone:	Cell Phone:	Text: ☐
Email Address:		
Additional Contact info (if needed)		
Preferred Contact Method:	Home Phone: ☐ Cell Phone: ☐	Email: ☐
MEDICAL CONCERNS/PRECAUTIONS:	*name/phone of medical/wellness provider:*	
TREATMENT GOALS:		

Authorization for Treatment: The undersigned hereby authorizes Holly Prouty (referred to as the provider) to render the client Craniosacral Therapy at their request or as deemed necessary by the provider.

Payment Responsibility: The client, or client's parent(s)/guardian(s), will be financially responsible for the payment at the time of service. I agree to give a 24 hr. notice if I need to reschedule or cancel my appointment. The client, or client's parent(s) are responsible for the payment for any missed appointments without a 24 hour notice.

I give permission for messages pertaining to my visit and followup care to be left on my voicemail.
I authorize release of my information to referring provider or lactation consultant.
I give my permission for a photo of myself and/or the client to be taken to further the knowlege of CST.
I understand no specific names will be publically used.

Signed by client/client's representative:	Date:
Relationship to the Client:	
How did you find me? ☐ Internet ☐ Referral/name	Other:
If someone referred you, please share their name so that I may thank them.	