Craniosacral Therapy (CST) Client Intake Form

Kindal Marshall, LMT 12103

Name: _____ **Email:** _____ **Phone:** _____

Address: _____**Age/DOB:** _____

Occupation: _____**Emergency contact/phone:** _____

Have you previously experienced CST? _____

Primary reason for today's visit: _____

Areas of complaint, pain, tension: _____

Please circle yes or no to the following:

Y N Do you wear contact lenses?
Y N Dentures?
Y N Tongue, lip of buccal ties - revised or diagnosed?

_____

Y N Have you had extensive dental work (braces, etc.)?

_____

Y N Car accident, serious fall or injuries?

_____

Y N Do you have any allergies? If so, please describe allergens:

_____

Y N Do you have arthritis? What type/where? Please describe:

_____

Y N Do you have any heart conditions? What type/where?

_____

Y N Do you have any spinal problems? What type/where?

_____

Y N Are you presently pregnant? How far along? Complications?

_____

Y N Have you had surgery? Recently? Complications?

_____

Y N Do you take prescribed medications? Please list:

_____

Y N Do you exercise or play sports on a regular basis?

Please describe: _____

Y N Are you receiving care-chiropractic, naturopathic, acupuncture, nutritional, herbal, homeopathic or hypnotherapy? Please circle or list others. _____

Y N Do you have any other physical or mental conditions which I should be made aware of?

If, yes, please describe: _____

Please read and initial:

_____ I understand that the Craniosacral Therapist does not diagnose, treat, nor prescribe medications for illness, disease or any other physical or mental disorders.

_____ I confirm that I am not currently presenting with, nor have I recently experienced, any acute or severe central nervous system or intracranial conditions. Specifically, I attest that I do not have a history of recent head, neck, or spinal trauma (including fractures or concussion), recent brain or spinal surgery, diagnosed cerebral aneurysms, cerebrospinal fluid (CSF)leaks, acute hydrocephalus, cerebral edema, vascular clots, or brainstem compression. I acknowledge that these conditions are strict contraindications for this treatment.

_____ It has been made very clear to me that craniosacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended I see a physician for any physical ailment that I might have.

_____ Because a Craniosacral therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Craniosacral therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

_____ Payment is due at time of visit. I understand that I will be financially responsible for a missed or rescheduled appointment in full if not cancelled or rescheduled by phone or text 24 hours prior to the reserved session time.

_____ I authorize Kindal Marshall, LMBT to speak with other healthcare providers that are involved in my care if needed.

I have completed the above information accurately and have read, understand, and take responsibility for the above statements.

Signature: _____ Print: _____ Date: _____