PEIRSMAN CRANIO SACRAL

**CRANIOSACRAL INTAKE FORM**

 We take privacy very seriously. Your personal information will never be shared.

Top of Form

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| **Your Contact Information** |
| Name |  |
| Date of Birth |  |
| Email |  |
| Address |  |
| Phone |  |

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| **Your Emergency Contact** |
| Emergency Contact Name |  |
| Emergency Contact Phone |  |

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| **Your Cranio Sacral Experience** |

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| What are your goals and intentions?*(check all that apply)* | | |  |
| Pain Relief | Boost Immune Function | Healing |  |
| Relaxation | Inner Exploration | Curiosity |  |
| Sleep Better | Mental Focus/Meditation | Emotional Release |  |
| Therapeutic | Mind/Body Awareness | Expand Knowledge of Craniosacral Therapy |  |
| Other (please list): |  | Increase Ability to Receive Healthy Touch |  |

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| What tools, practices and activities do you use to relieve stress and maintain your wellbeing? | | |
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| Have you ever had a craniosacral session? | Yes    No |

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| What prompted you to schedule a craniosacral session today? |
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| Where in your body do you hold tension? |
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| **Health Questionairre** |
| *The following questions help us to address concerns and assess any conditions that might be contraindicative to your craniosacral session. Please check all that apply and explain if necessary.* |

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| Do you have any of the following conditions? | | | |  | |
| Open Scrapes, Cuts or Wounds | Contagious Disease | Contagious Skin Condition |  | |  | |
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| Are you pregnant?     Yes      No |
| When is your due date? (MM, YYYY) |

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| Have you experienced any of these conditions?*(check all that apply)* | | | | | | | |  |
| Asthma | Headaches/Migraines | ADHD |  |  |  |  |  |  |
| Acid Reflux (GERD) | Recurrent Ear Infections | Autism |  |  |  |  |  |  |
| Fibromyalgia | Recurrent Sinus Infections | Anxiety |  |  |  |  |  |  |
| PMS | Immune Disorders | Panic Attacks |  |  |  |  |  |  |
| TMJ | Genetic Diseases | Depression |  |  |  |  |  |  |
| Tinnitus | Chronic Pain | Sleep Issues |  |  |  |  |  |  |
| Allergies | Whiplash |  |  |  |  |  |  |  |

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| How was your birth?*(check all that apply and explain if necessary)* | | | | | |  |
| Vaginal | Natural (No pain medications) | Long Labor | Hospital |  |  |  |
| C-Section | Epidural | Quick Labor | Home |  |  |  |

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| Allergies/sensitivity to oils or scents: |
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| Surgeries and/or Injuries (include approximate dates): |
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| Accidents, Traumas and/or Abuse you have experienced (include approximate dates): | | | | | |
|  |  | Emotional Abuse | Mental Abuse | Physical Abuse | None | |

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| Medications you are currently taking and the conditions they are related to: |
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| Other health concerns, mental/medical conditions and phobias that you have: |
| **Release of Liability** | |
| I understand that the craniosacral therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I further understand that craniosacral therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand that craniosacral therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because craniosacral therapy should not be performed under certain medical conditions I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.  I agree to give 48-Hour notice if I choose to reschedule or cancel an appointment for any reason other than a family emergency or sudden illness. If I cancel without 48-hour notice or do not show up to my appointment I agree to pay the full cost of the craniosacral therapy session.  I affirm the accuracy of the information I have provided and understand and agree to the policies above.  Print Name/Date  Signature/Date |  |

Bottom of Form