Craniosacral Therapy Intake Form

FLEMINGTON
CHIROPRACTIC CENTER

Please complete this required form before your session as thoroughly as possible. The information provided is kept confidential.

Pediatric CST Clients Only

Baby/Child Name: ______________________ Age today: __________

Birth Height: ________ Birth Weight: ________ Date of Birth: ______________

Length of pregnancy: ______________

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First Name: ______________ Last Name: ______________

Height: __________ Weight: __________ Date of Birth: ______________

Address: ______________________________

City: ______________ State: __________ Zip: __________

Phone: ______________ Email: ______________

Occupation: ______________________________

How did you hear about us? Please specify: ______________

If you are referred, who referred you: ______________

Name of your Family Physician: ______________

When was your last check up? ________ Results? ______________

Have you ever received a professional Craniosacral Therapy before?

No_____ Yes_____ If yes, when? ______________

Is the purpose of your visit:

- ☐ to address symptoms of PTSD or other Trauma?
- ☐ to address issues with breastfeeding?
- ☐ to relieve migraines or stress related disorders?
- ☐ to relieve tension from braces?
- ☐ relief for dental work/procedures?
- ☐ to address symptoms of ADHD?
- ☐ to help with sensory processing?
- ☐ to address symptoms of Autism?
- ☐ to address specific health concerns? (Please specify): ______________

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Do you experience headaches often? If so, please describe:

____

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Briefly detail any trauma event in your life: death, accidents, attacks, etc.:

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Any serious falls or injuries? If so, when: ______________

Any surgeries? If so, when: ______________

Any spinal problems? If so, please describe: ______________

Are you pregnant? If so, how many weeks? Complications? ______________

If you are taking any prescribed medications, please list: ______________

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Are you involved in sports or exercise on a regular basis? ______________

Any other physical or mental conditions to be aware of before proceeding with a Craniosacral Therapy session? If so, please describe: ______________

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Please read and initial:

_____ I understand that the Craniosacral therapist does not diagnose illness, disease, or any other physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals.

_____ I understand that Craniosacral therapy is considered to be a contraindication for recent injuries to the neck and head such as recent whiplash or fracture near the base of the neck, concussions, or hemorrhages, swelling, Chiari malformation, Aneurysm, or blood clots. Currently, I am not experiencing any of these conditions.

_____ I understand that Craniosacral therapy is not a substitute for medical examinations and/or diagnosis for any physical ailment that I might have.

_____ I understand that it is necessary for the Craniosacral therapist to be aware of any existing physical
conditions. I have stated above all my known medical conditions and intend to keep the Craniosacral therapist updated on my physical health for future sessions. I release the therapist from responsibility and liability for any adverse reactions resulting from the disclosed and undisclosed physical conditions.

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

Signature: _____ Date: _____

Therapist Notes Section