Anne Cartegnie, LLC.

CRANIOSACRAL & BIRTH-AND-PRENATAL THERAPY

Client Information Form - Craniosacral Therapy

CONFIDENTIALITY: All information on this questionnaire will be kept strictly confidential.

Name: ______________________________________ E-mail ________________________________
Address: _________________________ City __________________ State ______ Zip ___________
Phone: ______________ ❑ (Home) ❑ (Cell) - Age: ________ Birth Date: ________________
Occupation: _______________________________ - Referred by: ___________________________
Emergency contact person: _________________________________ Phone: __________________

❑ Yes ❑ No Have you previously experienced CranioSacral Therapy?
❑ Yes ❑ No Are you currently under a physician's care for any condition? Please describe:

____

Primary reason for today's visit. In a few words, please describe your goal for this session:

____

Areas of complaint, pain, tension, (please explain):

____

Please answer the following questions:

❑ Yes ❑ No Do you wear contact lenses?
❑ Yes ❑ No Do you wear dentures?
❑ Yes ❑ No Have you had extensive dental work (ie; braces, etc.)?
❑ Yes ❑ No Car accident (at any time), serious falls or injuries?
❑ Yes ❑ No Do you have any allergies? : ____
❑ Yes ❑ No Do you have arthritis?
❑ Yes ❑ No Do you have any heart problems?
❑ Yes ❑ No Do you have cancer?
❑ Yes ❑ No Do you have any spinal problems? Please describe:

____

❑ Yes ❑ No Are you presently pregnant? How far along? Complications?

____

❑ Yes ❑ No Have you had surgery, How recently? ____________________________________
Complications____
❑ Yes ❑ No Do you take any prescribed medications? Please list:

____

❑ Yes ❑ No Do you exercise or play sports on a regular basis? Please describe:

____

Are you receiving any other complementary care currently? Please check:
❑ chiropractor, ❑ naturopathic, ❑ acupuncture, ❑ nutritional, ❑ herbal, ❑ homeopathic,
❑ hypnotherapy, ❑ other: ____

❑ Yes ❑ No Do you have any other physical or mental condition of which I should be aware before giving you a CranioSacral session? If yes, please describe:

____

Please read carefully and initial:

______ If I experience any pain or discomfort during the session, I will immediately inform Anne so that the treatment may be adjusted to my level of comfort.

______ I understand that the CranioSacral therapist does not diagnose illness, disease, or any other physical or mental disorder. CranioSacral therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I might have.

______ I understand that craniosacral therapy is considered by some to be a contraindication for recent injuries to the head and neck, ie; recent whiplash, any recent fracture to base of the neck, concussion, hemmorage, cancer, as well as rheumatoid arthritis, and state that I am not currently experiencing any of these conditions.

______ I agree to keep the therapist updated as to any changes in my medical profile during the sessions.

______ Some people may experience mild discomfort after a treatment. This may be due to re-experiencing a trauma or injury or a previously numb area may come back to life and be more sensitive.

______ I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

Signature: ____ Date: __________________

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

NOTES: