Craniosacral Client Intake

Emily Martin, BCST, LMT

Name ________________________________ DOB______________ Phone _____________________

Address__________________________________ Occupation _________________________________

Address__________________________________ Email ______________________________________

Emergency Contact: Name, Relationship ____

Emergency Phone______________________________ Physician_______________________________

Please describe your current self care: ____

What is your intention or treatment goal? ____

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History Please list all that apply:
Breaks, sprains and surgeries, major and minor, can leave lasting patterns in the body; falls, auto accidents and injuries, even from early ages, apply. Please also list any medical concerns you are aware of including blood pressure or heart conditions, seizures, cancer and ongoing disorders including sleep or digestive disruptions, tinnitus, headaches, visual disturbances, etc.

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Please share any current, recent or ongoing situations or events causing higher than normal amounts of stress.

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How would you rate the following?
Poor (1) to (10) Fantastic
Sleep _____________
Mood_____________
Digestion__________

Do you experience any of the following?

Headaches	Sleep disruptions
Vertigo	Depression
Tinnitus/ringing in ears	Digestive issues
Numbness/tingling	Chronic Pain
Post Traumatic Stress	Anxiety

By signing below I certify that the above information is complete and correct. I will inform the therapist as changes occur if therapy is to be ongoing. I agree to be responsible for all financial obligations for services rendered including no show fee of $25 for appointments not cancelled 24 hours prior. I understand that neither the therapist or the facilities shared/used by the therapist are will be liable for any injuries or loss sustained to myself or property while on the premises. In addition the therapist disclaims responsibility for injury sustained during stretches or excercised that may be suggested. I will not begin excercises or stretches without first consulting my physician.

Client Signature__________________________Date_________ Therapist ______________Date_______