CranioSacral Therapy (CST)
Client Information Form

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

Client Name: **Age/DOB:**
Parent/Guardian Name:
Address:
Phone (best way to reach you):
Email:
Referred by:

Has child previously experienced CranioSacral bodywork?

Primary reason for today's visit:
Areas of complaint, pain, tension:

In a few words, please describe your goal for this session:
Are you aware of any emotional distress from the time of an injury?

Has child suffered any form of abuse their body may be holding?

Gestation History

Length of pregnancy:
Did any of the following occur during pregnancy? (circle one) none
Accidents New diagnosis medications
If yes, please describe:

Labor/Delivery History

How long was labor?
How much time was spent pushing?

Was mother induced?
Which methods of pain control were used? none

What was baby's presentation at birth?	Normal	Breech
What type of delivery did your child have?	Vaginal	C-Section
Were forceps or suction used to assist in your child's delivery?		YES/NO
Did you child breathe on his/her own after being delivered?		YES/NO
Any concerns with the umbilical cord during birth?		YES/NO

If yes, choose: loosely wrapped tightly wrapped knotted
Where was it wrapped?

Post-Natal History

Was your baby in intensive care? YES/NO

Was your baby blue after delivery? YES/NO

Did your baby struggle latching to bottle or breast? YES/NO

Did your baby spit up frequently? YES/NO

Did your baby have colic? YES/NO

Did your baby have constipation? YES/NO

Did your baby have strabismus (lazy eye)? YES/NO

How was his/her sleep schedule?

Please answer yes or no to the following:

Y N Does child wear eye glasses?

Y N Mouth appliances?

Y N Has the child had extensive dental work (braces, etc)?

Y N Tongue, lip of buccal ties - revised or diagnosed?

Y N Car accident, serious fall or injuries?

T A Does your child have a typical or adjusted vaccination schedule? Reactions?

Y N Does child have any allergies? If so, please describe allergens:

Y N Does child have arthritis? What type/where? Please describe:

Y N Does child have any heart problems? What type/where?

Y N Does child have any spinal problems? What type/where?

Y N Has child had surgery? Recently? Complications?

Y N Does child take prescribed medications? Please list:

Y N Does child exercise or play sports on a regular basis? Please describe:

Y N Is child receiving any other complementary care (chiropractic, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? Please describe:

Y N Does child have any other physical or mental condition of which I should be aware before giving your child a CranioSacral session? Please describe:

Please list supporting providers (first and last name):
Lactation Consultant:
Chiropractor:
Pediatrician:
Dentist if TT released:
Other:
Please read and initial:

_____ I understand that the CranioSacral bodyworker does not diagnose illness, disease or any other physical or mental disorder. In addition, the CranioSacral bodyworker does not prescribe medical treatment of pharmaceuticals.

_____ I understand that the craniosacral bodyworker is considered to be a contraindication for recent injuries to the head and neck, ie; whiplash, any recent fracture to base of the neck, concussion, hemorrhage, as well as rheumatoid arthritis, and state that my child is not currently experiencing any of these conditions.

_____ 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 that I see a physician for any physical ailment that I might have.

_____ Because a craniosacral bodyworker must be aware of existing physical conditions, I have stated all my child's known medical conditions and take it upon myself to keep the craniosacral bodyworker updated on my child's physical health for future sessions. Further, I release the bodyworker 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 if not cancelled/changed by phone/text 24 hours prior to the reserved session time.

Y/N I give permission for Pinal Patel to consult with other care providers that I am working with to provide the best care for my child.

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

Therapist notes: