Soulful Truth

Integrative Healing, Craniosacral Therapy

Client Information Today's Date: _____

Name: _____ Birth Date: _____

Phone (Cell): _____ Email: _____

Address: _____ City: _____ Postal Code: _____

Sex: _____ Preferred Pronouns: _____

Emergency Contact Name: _____ Phone: _____

Parent Contact (If patient is under 18yrs old): _____

How did you hear about us? _____

Health Information

Current symptoms/concerns/comments about overall health or wellbeing

_____

_____

_____

Do you currently have any medical diagnoses by a medical professional?

_____

_____

_____

Do you currently have any mental health diagnoses by a medical professional?

_____

_____

_____

Are you currently taking any medications? If so, please list

_____

_____

_____

Have you ever had an aneurysm? □ Yes | □ No

How would you rate the current state of your emotional well-being?

1	2	3	4	5	6	7	8	9	10
Un Well				Neutral					Very Well

How would you rate the current state of your physical body?

1	2	3	4	5	6	7	8	9	10
Un Well				Neutral					Very Well

How would you rate the quality of your sleep at night?

1	2	3	4	5	6	7	8	9	10
Un Well				Neutral					Very Well

How would you rate your stress levels?

1	2	3	4	5	6	7	8	9	10
Low Stress				Neutral					High Stress

How is would you rate your anxiety levels?

1	2	3	4	5	6	7	8	9	10
Low Anxiety				Neutral					High Anxiety

Do you have any concerns about your digestion? Constipation or diarrhea?

_____

_____

Do you have any concerns about your hormones? Painful periods? Menopause? HRT?

_____

_____

Have you had any surgeries in the past?

_____

_____

Have you been in any car accidents, or had any serious injuries or falls?

_____

_____

Are you currently, or have you in the past, grieved any loved ones?

_____

_____

Do you practice any self-care? If not, is that something that you would be interested in developing?

_____

_____

Have you, throughout your life span, experienced any trauma? □ Yes | □ No

Are you currently pregnant? □ Yes | □ No

Informed Consent

By signing below, I hereby voluntarily consent to Hands on Healing - Craniosacral Therapy (CST) Treatment

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that Craniosacral Therapists are not primary care providers. I clearly understand that CST is not a substitute for a medical examination, medical treatment or medication.

I acknowledge that no assurance or guarantee has been provided to me as to the results of a therapy treatment session or series of sessions. I acknowledge that with any treatment there can be risks and those have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical and life conditions. I have disclosed to the therapist all of those medical and life conditions affecting me.

It is my responsibility to keep the therapist updated on my medical history and any life conditions that may affect my treatment.

The information I have provided is true and complete to the best of my knowledge. I have read the above noted consent and I have had the opportunity to question the contents and the therapy.

By signing this form, I confirm my consent to treatment today and include consent for additional treatment proposed by my therapist. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____

(PATIENT SIGNATURE)

_____

(DATE)

_____

(PRACTITIONER SIGNATURE)

_____

(DATE)

We understand circumstances arise, however, please note a fee of 75% of the scheduled CST fee will be applied for multiple missed or cancelled appointments without 24 hours' notice.

_____ Initial