CLIENT INFORMATION

Return to Being Your Oneness — Compassion is my Compass

PERSONAL INFORMATION

Name _____ DOB _____

Address, City, State, Zip _____

Phone # _____ Email _____

Referred By _____ Occupation(s) _____

CRANIOSACRAL THERAPY HISTORY

Have you had a session before? _____ When? _____ Number of sessions? _____

MEDICAL HISTORY

Medications _____

Recent dental work _____

Please indicate any conditions you currently have or have had in the past:

- ☐ accidents/falls
- ☐ anxiety
- ☐ arthritis
- ☐ back injury
- ☐ broken bones
- ☐ cancer
- ☐ fibromyalgia
- ☐ headaches/migraines
- ☐ heart/circulation problems
- ☐ neck problems
- ☐ numbness
- ☐ sprains/strains
- ☐ stress
- ☐ surgery
- ☐ tinnitus/ringing in ear/ears
- ☐ TMJ issues
- ☐ vertigo/dizziness
- ☐ trauma
- ☐ other _____

Please explain any conditions you marked:

_____

_____

What is/are your goal(s) for your session(s)?: Are you able to comfortably lie on your back for an hour? ☐ Yes ☐ No

_____

_____

_____

I consent to CranioSacral Therapy with a Biodynamic Perspective (CSTBP) with Laura Schappert and to future communications from Laura Schappert by email/and or telephone. I understand appointments cancelled less than 24-hour notice are subject to a cancellation fee. My written signature or typed name below indicates my consent. All discussions are kept confidential. I understand that: (1) practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional; (2) CSTBP does not take the place of medical care; (3) CSTBP can complement any medical or psychological care I may be receiving; (4) the body has the ability to heal itself, complete relaxation is often beneficial; and (5) long-term imbalances may require multiple sessions to facilitate the relaxation needed for the body to heal.

Signature _____ Date _____