ADULT CLIENT INFORMATION Please fill in as applicable and sign on 2nd page. Thank you. *Emily Klik LMT CST*

Name:____ DOB:________________________

Address____________________________City_____________________State/Zip________________

Cell Phone__________________________Other contact number____________________________

Email Address____

Referred by:____ May I thank them:___Y / N__

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Have you received Craniosacral therapy in the past? Yes / No Date of last treatment:________________

For what condition/s?____

Reason/s for seeking CranioSacral Therapy today: (anxiety/ stress, headache, body pain, injury, etc)

____

What symptoms are associated with your intention for receiving CranioSacral Therapy (current and past)?

____

Please list any parts of your body that store or harbor stress and/or anxiety:

____

Please describe typical activities of daily living (work, activity level, exercise etc):

____

Please list any other conditions, symptoms, recent stressors/ crisis, or health history that you feel is significant:

____

Have you had surgery to correct strabismus or any other eye movement difficulties? Y / N

Have you had COVID? Y / N When?_________ Received COVID vaccine(s)? Y / N When? ____________

Lingering symptoms of COVID or vaccine?____

Do you have any other concerns or questions about CranioSacral Therapy?_________________________

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Other relevant medical history. Please circle any of the following which currently apply to you; mark any that occurred in the past with a "P".

Allergies	Aneurysm*	Arthritis	Asthma
Balance problems	Blood clots	Braces / palate exapnder	Brain fog
Bronchitis / Pneumonia	Cancer	Cerebral hemorrhage*	Chronic Pain
Clenching / grinding	Depression	Diabetes	Dizziness / Vertigo
Ear noises/popping	Epidural leaks*	Female Issues	Fibromyalgia
Fibrotic cysts	Fracture of spine or skull*	Heart condition	High/Low BP
Hip Replacement	Joint disease	Loss of taste / smell	Male Issues
Numbness	Osteoporosis*	Pacemaker	Poor Circulation
Pregnant	Respiratory/lung	Rheumatoid arthritis*	Sciatica
Scoliosis	Seizures	Sinus issues	Sleep issues
Speech Issues	Stroke*	Stress / anxiety	Swallowing issues

Please list any other conditions, symptoms, or health history that you feel is significant:

_____

CONSENT FOR CARE

You have the right to seek a second opinion or to end the therapy session at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist (Emily Klik LMT CST) for information about her training and credentials.

I, _____, understand that CranioSacral Therapy is not a substitute for standard medical care, and I have indicated all of my known medical conditions. I will alert the practitioner to any changes in my health status, including medication changes. It is my choice to receive CranioSacral Therapy with an understanding of the risks and benefits, and I give my consent for treatment. I understand that there is no stated guarantee for effectiveness of treatment.

Signature_____Date_____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Fee is a sliding scale of $75-125 per hour session. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness, complications of illness, weather-related events and true emergencies). In the present pandemic, there is no fee for late notice cancellations in the Skokie office.

As a wellness service, Craniosacral Therapy and Massage Therapy are not covered by most health insurance policies.

Please initial understanding of payment policy: _____