CranioSacral Therapy
Joyce Bryan, CMT, CST-T

Adult Intake Form

Client Name: _____ Phone: _____

Address: _____

Email: _____

Birth Date: _____ Referred By: _____

Emergency Contact: _____ Phone: _____

Why are you requesting a session today? _____
_____

Have you received professional bodywork sessions in the past? _____

If so what type? _____

Illnesses, surgeries, and/or traumas I should know about: _____
_____
_____
_____

For Women
Are you pregnant? _____ Due Date? _____

Any problems with your pregnancy? _____

Please note: If you have a specific medical condition, or specific symptoms, CranioSacral Therapy may be contraindicated. A referral from your primary care provider may be required.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in medical profile, and understand that there will be no liability on the practitioner's part should I forget to do so.

Client/Guardian signature:_____

Date:_____