Joyce Bryan, CMT, CST-T
CranioSacral Therapy

Pediatric Intake Form

Child Name: ____

Parent/Guardian Name: ____

Emergency Contact: ______________________________ Phone:______________

Why are you bringing your child for a session today? ___________________________

What type of therapy, if any, has your child received for this condition in the past?

Any Illnesses, surgeries, and/or birth trauma I should know about?

If your child has a specific medical condition, or specific symptoms, CranioSacral Therapy may be contraindicated. Depending on your reason your child is receiving CranioSacral Therapy, a referral from your primary care provider may be required for you to be reimbursed by your insurance company.

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 my child's medical profile, and understand that there will be no liability on the practitioner's part should I forget to do so.

______________________________________ ______________________

Parent/Guardian Signature **Date**