Craniosacral Therapy (CST) Intake Form *Mei Leslie, LMT, CST-T*
Selah Massage & Bodywork

Client Information

Name _____ Date _____

Address _____ City, State & Zip _____

Phone_____(Circle: Cell / Home / Work) Email _____

I prefer to receive appointment reminders via: ❑ Text ❑ Phone call/Voice mail ❑ Email

Birthday_____/_____/_____ Occupation_____

Emergency Contact _____ Phone _____

❑ Yes ❑ No Have you had Craniosacral Therapy before?
❑ Yes ❑ No Are you presently under the care of a physician/osteopath/naturopath, chiropractor, physical therapist, counselor, psychotherapist or other health care practitioner?

❑ Yes ❑ No May I contact?

Name_____Phone_____

Please indicate your reason for seeking treatment: _____

_____

Health & Medication Information

Please list the date and nature of any past injuries, illnesses, traumas, chronic conditions, surgeries, **and current medications**. Use back of form, if needed.

_____

_____

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_____

Check any that apply:

- ❑ Contact lenses
- ❑ Dentures
- ❑ Allergies
- ❑ Arthritis/Osteoporsis
- ❑ Hearing aids
- ❑ Hair pieces (wigs, extensions)
- ❑ Recent stroke/aneurysm
- ❑ Recent epidural/spinal tap
- ❑ Extensive dental work (braces, bridgework, implants)

IMPORTANT! ***Please read and sign:***
If you have a specific medical condition or specific symptoms, Craniosacral Therapy (CST) may be contraindicated. A referral from your Primary Care Provider may be required.
I affirm that I have stated all my known medical conditions. I agree to keep the therapist updated as to any changes in my medical profile and understand that the therapist is not liable should I forget to do so. I understand that CST is provided for the purpose of relaxation. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the technique may be modified to my comfort level. I understand that CST is not a substitute for medical examination, diagnosis, or treatment and that I should seek a qualified medical specialist for any physical or mental disorder I may have. Information exchanged during the session is educational in nature and intended to help me become more conscious of my own health status. I understand that the therapist does not perform spinal manipulations, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. I consent to have CST and do not hold the therapist liable for complications that may arise as a result of the session.

Client Signature _____ Date _____