NOURISH
Craniosacral Therapy

Client Name: _____ Date: _____

Date of Birth:_____ Pronouns:_____
Address:_____
Phone: _____ Email:_____
Referred by: _____
Emergency contact: _____ Phone: _____
Physician/Health-care Provider: _____ Phone: _____

What are your goals/expected outcomes for receiving craniosacral therapy?

_____
_____

How do you feel today? _____

Have you had a fever in the last 24 hours of 100 deg F or above, or have you recently had any respiratory symptoms, sore throat, or shortness of breath? Have you been in contact with anyone in the last 10 days who has been diagnose with COVID-19 symptoms? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness, swelling, depression, etc.):

_____
_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No
Explain:

_____
_____

List the medications you currently take:

_____
_____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask): recent concussion/trauma, blood clots, infections, congestive heart failure, contagious diseases, pitted edema.

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Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

_____ **Current Past** Muscle/Joint Pain/Stiffness/Numbness/Tingling
_____ **Current Past** Swelling/Bruising Easily/Touch Sensitivity
_____ **Current Past** High/Low Blood Pressure
_____ **Current Past** Stroke, Heart attack/Varicose Veins
_____ **Current Past** Shortness of Breath, Asthma
_____ **Current Past** Cancer
_____ **Current Past** Neurological(MS, Parkinson's, Seizures, Neuropathy)
_____ **Current Past** Headaches/Migraines/Dizziness/Ringing in Ears/TMJ
_____ **Current Past** Digestive Conditions (e.g. Crohn's, IBS)/Diabetes
_____ **Current Past** Gas, Bloating, Constipation, Diarrhea
_____ **Current Past** Kidney Disease, Infection
_____ **Current Past** Arthritis (Rheumatoid, Osteoarthritis)
_____ **Current Past** Spine issues/Broken bones/Surgery
_____ **Current Past** Allergies
_____ **Current Past** Endocrine/Thyroid Conditions
_____ **Current Past** Depression, Anxiety, Memory loss, Overwhelm
_____ **Current Past** History of Assault/Abuse/Trauma

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform Danelle. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment. I understand that bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because bodywork should not be performed under certain medical conditions, 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 medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I also understand that missed appointments (emergencies and illness excluded) without twenty-four (24) hour notice will be charged in full.

Understanding all of this, I give my consent to receive care or consent for my child to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (if under 18 years old): _____ Date: _____

I give my consent to communicate with Living Nourish through text messaging, excluding personal health information. I understand I can opt out at any time. Client Signature _____