Living Well Massage

Client Information Form

CranioSacral Therapy

Name:_____ Date:_____

Address: _____Date of Birth:_____

Email Address:_____Phone:_____

Occupation:_____

Emergency Contact:_____

Have you previously experienced CranioSacral Therapy?_____

Are you currently under a physician's care for any condition? If yes, please describe:_____

_____

Physician's name:_____Phone:_____

Primary reason for today's visit:_____

Areas of complaint/pain/tension:_____

_____

In a few words, please describe your goal for this session:_____

_____

Do you have any other physical or mental condition of which I should be aware of before giving you a CranioSacral session?_____

_____

I understand that the CranioSacral therapist does not diagnose illness, disease or any other physical or mental disorder. It has been made clear to me that CranioSacral Therapy does not substitute medical examinations. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from this CranioSacral Therapy session.

_____ _____

Signature Date