Helen Russell, RCST®

Registered CranioSacral Therapist

Initial Intake Form Collected information is confidential.

Name: Date of Birth:

Occupation:

Address:

Email:

Telephone Landline: Cell:

Emergency Contact: Telephone:

Current Health Concerns:

Previous Medical History:

Previous Illnesses:

Surgeries:

Accidents:

Current Medications and/or Supplements:

Have you had any dental work (braces, implants)? Please list details:

Do you know any details of your own birth?

Women Only:

If you have children, what can you tell me about their births?

Are you pregnant or trying to conceive?

What are your expectations for craniosacral therapy?

Please list any additional comments regarding your health and well-being:

Who can I thank for your referral?

Additional Notes:

Informed Consent:

I, (Client) understand that the Biodynamic Craniosacral Therapy provided by Helen Russell, RCST® (Therapist) is intended to reduce pain, integrate structural imbalances, decrease myofascial restrictions, decrease neural impingement, increase range of motion, improve circulation, enhance relaxation, increase the experience of overall health and offer a positive experience of touch.

I understand that Biodynamic Craniosacral Therapy is not a substitute for medical treatment or medications, and that it is recommended that I work concurrently with my Primary Caregiver for any condition I may have. I am aware that the Therapist does not diagnose illness or disease and does not prescribe medications.

I have informed the Therapist of all known physical conditions, medical conditions and medications, and I will keep the Therapist updated regarding any changes.

I have considered the benefits, risks and alternatives to the treatment to be provided to me and will not hold responsible the Therapist, and/or associated health professionals for unforeseen occurrences that could possibly occur.

**If you must cancel or reschedule your appointment, at least 24 hours advance notice is required. This allows those on a wait list the opportunity to receive treatment. There will be a charge for the full cost of any missed appointments without adequate notice.**

Client Signature: Date: