Pediatric Craniosacral In-take Form

Child's Name: _____ D. o. B._____

Address_____

BestTelephone_____E-mail_____

Mother's/Father's Name: _____

Sibling(s)(name/age: _____

Referred by: _____

HEALTH CARE PROVIDERS

Pediatrician
_____

Occupational Therapist
_____

Lactation Consultant
_____

Physical Therapist
_____

Chiropractor
_____

Other
_____

PREGNANCY & DELIVERY

Length of Pregnancy: _____

Any problems during pregnancy?_____

Type of Delivery: _____

Length of Labor; how labor started and progressed:
_____
_____
_____
___

Please describe any problems at birth (include C Sections, VBAC, Suction/Forceps delivery, etc.):_____
_____

SYMPTOMS & COMPLAINTS

What concerns have brought you to seek CST for your child?

Please list the child's major complaints, symptoms: be as specific as you can.

How do you believe it all began?

What is the child's official diagnosis?

MEDICAL HISTORY

Please indicate any previous medical issues your child has experienced: : illnesses, diseases, fractures, allergies, digestive problems, accidents, trauma (All trauma in the past: accidents, falls and injuries are important):

List any surgery your child has undergone and dates:

List all medications (including supplements, herbs, over the counter drugs) your child is presently taking:

List any diagnostic tests (Xray, MRI, etc.) your child had and the results:

Release of Liability and Client Responsibility

Please take a moment to carefully read the following information and sign where indicated. Your signature indicates that you have agreed to these terms.

If your child has a specific medical condition or specific symptoms, massage/craniosacral therapy may be contradicted. Because massage/craniosacral therapy and developmental movement therapy/reflex integration should not be performed under certain medical conditions, I affirm that I have stated all my child's known medical conditions and answered all the questions honestly. I agree to keep the practitioner updated as to any changes in my child's medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. A referral from your primary care provider may be required prior to service being provided.

I understand that the myofascial massage and craniosacral therapy that my child receives is provided for the basic purpose of relaxation of connective tissue tension and restoration of the craniosacral rhythm. I understand that developmental movement therapy/reflex integration is provided for the activation of key neural connections. If I notice that my child is experiencing any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my child's level of comfort.

I further understand that myofascial massage/craniosacral therapy and developmental movement therapy/reflex integration 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 ailments of which I am aware of in my child. I understand that massage/craniosacral therapy practitioners and developmental movement therapy/reflex integration 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.

I,_____ (parent's name), agree to the following during and after the course of my child's therapy.

Please Initial:

1. At any time during a session, I have the right to stop the therapy if I feel uncomfortable_____.

2. I understand that the therapist is committed in assisting my child to heal her/himself in the shortest time possible._____.

3. I understand that there may be reactions to treatment, anticipated or unanticipated, and that it is my responsibility to discuss any concerns with the therapist_____.

Payment Policy : Payment is due on the day of service. I can generate a statement for your insurance carrier or flex plan to facilitate your reimbursement request. Please check your benefit coverage first. Your service may be eligible for flex plan coverage if your employer offers this benefit.

Client statement: I understand that payment is due on the day of service. Further, I agree to pay a processing fee of $25 for each payment that is not made on the day of service and additional bank fees for any check or debit that does not clear. I understand that the practitioner may discontinue sessions if payments are not current.

Cancellation Policy: Client statement: I agree to comply with the cancellation policy, which requires 24 hours notice to Heather Becton Hunt for any rescheduled or canceled appointment. If I do not provide 24 hours notice, I will be responsible to pay the posted fee.

Parent/Guardian Signature _____ Date _____