Blanca Noel

Soul Dialoguing CranioSacral Therapy
CLIENT INFORMATION

Name_____ **Telephone (___)**_____ **Date of Birth**_____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Referred by_____ **Telephone (___)**_____

In Case of Emergency_____ **Telephone (___)**_____

General & Medical Information

Occupation_____ **Age** _____ ☐ **male** ☐ **female** **Physician** _____

Please take a moment to answer the following questions and sign this form. If you have a specific medical condition or specific symptoms, this therapy may be contraindicated. A referral from your primary care provider may be required.

☐Yes ☐No Have you ever experienced a professional CranioSacral/holistic therapy session? How recently? _____

Note: If you answer "yes" to any of the following questions, please explain as clearly as possible in the comments section below.

☐**Yes** ☐**No** Do you frequently suffer from stress?
☐**Yes** ☐**No** Do you have diabetes?
☐**Yes** ☐**No** Do you experience frequent headaches?
☐**Yes** ☐**No** Are you pregnant?
☐**Yes** ☐**No** Do you suffer from arthritis?
☐**Yes** ☐**No** Are you wearing contact lenses?
☐**Yes** ☐**No** Are you wearing dentures?
☐**Yes** ☐**No** Do you have high blood pressure?
☐**Yes** ☐**No** If you answered yes to the previous question, are you taking medication for this?
☐**Yes** ☐**No** Do you suffer from epilepsy or seizures?
☐**Yes** ☐**No** Do you suffer from swelling of the joints?
☐**Yes** ☐**No** Do you have varicose veins?
☐**Yes** ☐**No** Do you have any contagious diseases?
☐**Yes** ☐**No** Do you have osteoporosis?

☐**Yes** ☐**No** Do you bruise easily?
☐**Yes** ☐**No** Have you had any broken bones in the past two years?
☐**Yes** ☐**No** Have you been in any accidents or suffered any injuries in the past two years?
☐**Yes** ☐**No** Do you have any tension or soreness in a specific area? Please specify:_____
_____
☐**Yes** ☐**No** Do you have cardiac or circulatory problems?
☐**Yes** ☐**No** Do you suffer from back pain?
☐**Yes** ☐**No** Do you have numbness or stabbing pain anywhere? If so, where?_____
☐**Yes** ☐**No** Are you sensitive to touch in any area? If so, where?_____
☐**Yes** ☐**No** Have you ever had surgery? Please explain below.
☐**Yes** ☐**No** Do you have any other medical condition or are you taking any medications I should know about?

Comments:_____
_____

I understand that the CST/Soul Dialoguing holistic therapy I receive is provided for the basic purpose of relaxation and stress relief. If I experience any pain or discomfort during this session, I will immediately inform the practitioner. I further understand that CST/Soul Dialoguing holistic therapy 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 of which I am aware. I understand that CST/holistic therapy 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 CST/holistic therapy 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.

Client Signature_____ **Date**_____

Practitioner Signature_____ **Date**_____

Consent to Treatment of Minor: By my signature below, I hereby authorize_____ **to administer CST/holistic therapy or Soul Dialoguing to my child or dependent as they deem necessary.**

Signature of Parent or Guardian_____ **Date**_____

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